Recovery in bipolar disorder: A qualitative study exploring the views of mental health professionals using grounded theory.

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Contents

List of Tables:

List of Figures:

Appendices

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Introductory Chapter: Thesis Overview

The overarching aim of the current thesis was to examine the views of recovery for bipolar disorder (BD). The review chapter presents an introduction to the topic of recovery in BD and the views of various stakeholders for this area.

Recovery in BD has been defined by two models, clinical and personal recovery. Clinical recovery is defined as focussing on criteria of observable, clinical outcomes such as symptom reduction, avoiding rehospitalisation (Michalak et al., 2006), medication adherence, and reducing the risk of relapse (Castle et al., 2009; Lobban et al., 2010). These clinical outcomes are often measured subjectively through clinicians' assessments, ratings, and decisions, rather than service users' views (Kwok, 2014; Veseth et al., 2017).

However service users have been found to place no value in clinical recovery (Mansell et al., 2010), instead emphasising the importance of personal recovery, such as living well without medication (Cooke et al., 2010; Mansell et al., 2010), self-acceptance and redefining the sense of self (Cooke et al., 2010), feeling empowered and in control of their own lives (Warwick et al., 2019), separating themselves from their diagnostic label (Russell & Browne, 2005), and able to achieve ones' goals (Cooke et al., 2010). These individualised concepts of recovery are in contrast to the clinical practices professionals work towards, following support from clinical guidelines, evidence-based practice, and care pathways (Slade, 2010).

Findings from the first chapter highlighted a possible divide between service user and professional views for recovery in BD, however the first chapter described a limited number of studies that had been carried out exploring professional views of recovery for BD, none of which had been conducted within the UK.

As a result, chapter two presents an empirical investigation to explore a preliminary understanding of healthcare professionals' views of recovery for BD.

Despite national efforts to increase recovery-based training (Alderwick & Dixon, 2019) and an increased understanding of service users placing value on personal recovery

approaches (Mansell et al., 2010), professionals were found to largely follow a traditional clinical approach to recovery for BD.

Emerging literature on professional views of recovery in BD from countries other than the UK (Maassen et al., 2019; Veseth et al., 2016, 2017, 2019), supported some findings from this study, such as a preference for clinical models and use of medication for symptomology and relapse prevention. Personal narratives of recovery were often mis-conceptualised, and involved professionals identifying their own goals on behalf of service users. Professionals from more medicalised backgrounds and settings such as psychiatry and inpatient settings also described a lack of knowledge and training in these areas, which relates to findings suggesting professionals know and understand more about treating illnesses rather than promoting wellbeing (Slade, 2010). However, long-term recovery was also viewed as being the responsibility of service users and their wider support network, as professionals described service level barriers to recovery such as large caseload numbers and a pressure to discharge service users before recovery goals could be implemented.

This study highlights the need for more awareness of personal recovery among professionals working with service users with BD, and support in identifying personal recovery goals, along with their implementation.

It is anticipated that the review chapter will be submitted to Clinical Psychology Review, and the empirical chapter will be submitted to Journal of Clinical Psychology. Consequently, chapter have been prepared in line with the relevant author guidelines (Appendix A and E respectfully).

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Chapter 1: Systematic Review

Highlights

- Previous research related to recovery in mental health has identified two models for recovery, clinical and personal recovery
- A systematic review revealed 15 identified studies consisting of 9 discussing service user views, 4 with professional views, 1 with a combination of both service user and professional views and only 1 study looking at carers' views.
- At present, initial findings suggest that service user views follow a personal recovery model which differs from the clinical model of recovery professional views described.
- Although limited conclusions can be drawn from carers' views, initial finding show that carers views remain mixed between personal and clinical recovery approaches.
- Service users may benefit from more flexible, individualised, and personal recovery focussed mental healthcare, compared to clinically informed recovery approaches currently provided by professionals and healthcare services.

Abstract

Background: Despite increasing evidence for recovery in wider mental health, less evidence is available for recovery in bipolar disorder (BD). Initial findings suggest that service users identify more towards personal recovery, and healthcare professionals towards a clinical model of recovery, however no evidence has compared different populations to see how these views could differ.

Aims: To conduct the first thematic synthesis to evaluate qualitative studies exploring different stakeholder views of what recovery is for individuals with BD.

Method: A systematic search of relevant databases was conducted using predefined search terms related to 'Bipolar' 'Stakeholder' 'Recovery' and 'Qualitative method'. A thematic synthesis was used to describe and compare the findings.

Results: The review yielded 15 papers from 12 identified research studies. All stakeholders believed that support and an increased understanding were key for recovery. Service user's prioritised feeling empowered and responsible for their own recovery, whereas professionals valued medication adherence and psychoeducation, and carers prioritised social integration and peer support.

Conclusions: Service users with BD could benefit from a flexible healthcare system that incorporates personal recovery further into clinical practice. Further research is needed however to further examine alternative stakeholder views on recovery.

Keywords: Bipolar disorder, recovery, professionals, family, carers, personal accounts.

Introduction

Within the UK recovery has become a priority for policy and clinical guidance for NHS services (e.g., Department of Health, 2011; National Institute of Health and Care Excellence [NICE] 2014), with national changes being made to focus more on recovery (Shepherd et al., 2008). Mental health literature on recovery has become more prominent over the last 30 years (Grover et al., 2016) and describe two contrasting concepts of recovery; clinical and personal recovery (Slade et al., 2012).

The clinical recovery concept has emerged from the expertise of service providers and healthcare organisations (Brooks et al., 2011; Gooding, 2006). Healthcare in the UK is driven by evidence-based clinical guidance from NICE, who produce guidelines which are a tool to support clinical decision making based on research evidence (Hay et al., 2008; Maassen et al., 2019) for assessments, diagnosis, and treatment. These all aim to reduce or complete remission of symptoms through medication and psychosocial rehabilitation (Frese et al., 2009).

Research into recovery and recovery-oriented care in mental health has focussed on individuals with schizophrenia or psychosis (Mueser et al., 2012), but is currently underrepresented in BD research (Jones et al., 2012, 2013; Maassen, Regeer, Bunders, et al., 2018; Tse et al., 2014). BD is considered to be a severe and lifelong mental health diagnosis, characterised by significant fluctuations in mood, ranging from severe depression to extreme mania and irritability, often accompanied by difficulties in functioning within society (Warwick et al., 2019).

Clinical recovery for BD focuses more on measurable symptoms with an assumption that improved function will follow. The treatment of BD in clinical guidelines remains predominantly focused on the alleviation of acute symptoms and relapse prevention (Leboyer & Kupfer, 2010), However clinical models that professionals work within do not meet the needs of recovery according to service users (Maassen, Regeer, Regeer, et al.,

2018), who do not value traditional clinically relevant outcomes (Jones et al., 2012; Mead & Copeland, 2000; Pitt et al., 2004).

The concept of recovery however has moved away from a dominant, clinical recovery model aimed at treating mental illness towards a personal recovery-focussed approach (Grover et al., 2016). A much-used definition of personal recovery has defined it as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness " (Anthony, 1993, p527). This directly contrasts with the clinical model of recovery being an elimination of symptoms.

One of the most accepted theoretical frameworks to understand personal recovery is CHIME (Leamy et al., 2011), which summarises recovery as an active journey that is influenced by five interrelated recovery processes: Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment. As recovery-oriented practices that support these processes are now expected of mental health services and professionals following changes to national guidance such as the NHS long term plan (Alderwick & Dixon, 2019), professional perspectives are central to the adoption of recovery-orientated practice. However mental health professionals have shown to have poor understanding of personal recovery, instead placing more emphasis on traditional approaches to recovery such as symptom management and compliance with treatment (Bedregal et al., 2006). Current evidence also identifies the lack of a shared understanding of what recovery means in practice as a fundamental impediment to successful implementation (Flottorp et al., 2013; Le Boutillier et al., 2015).

The individualistic nature of personal recovery may also present a challenge for mental health professionals. Providing individualised, personal recovery focussed approaches, such as personal choice and self-determination could differ from their professional experience and knowledge which is based around established, fixed concepts and processes such as clinical guidelines, evidence-based practice, and care pathways (Slade, 2010).

Explored narratives from individuals with BD have emphasised personal recovery as viewing themselves as being separate to any diagnostic label (Russell & Browne, 2005) and functioning well without medication (Cooke et al., 2010; Mansell et al., 2010). Service users also valued self-acceptance and redefining the sense of self (Cooke et al., 2010), becoming empowered and feeling in control of their lives (Warwick et al., 2019), and able to achieve one's goals (Cooke et al., 2010). Yet, for many professionals, BD treatment has traditionally followed a more medicalised approach (Veseth et al., 2019), focussing on issues such as symptom deficit, medication and risk (Davidson & Roe, 2007), alleviation of acute symptoms and relapse prevention (Leboyer & Kupfer, 2010) and therefore difficult to incorporate personal recovery concepts into their professional work (Veseth et al., 2019).

Limited research into carers views of recovery in wider mental health have found differences for how recovery is perceived, with carers more likely to focus on the absence of symptoms and improved functioning, compared to service user views on identity transformation and gaining meaning in life (Jacob et al., 2017). However, carers' narratives for wider mental health research have described feeling marginalised, not listened to by services, and not taken seriously (Cree 2015). Professionals have described however that despite some positive aspects of involving carers into recovery plans, personal relationships may also contribute towards frustrations or even distress through different opinions or over involvement in care at times. This could become a major barrier for the service users' processes of recovery as well as be a key factor in their recovery processes (Veseth et al., 2017).

Despite the recent increase in literature for recovery, it appears that different stakeholders appear to have different definitions of recovery from mental illness, and that the notion of recovery has become the focus of a considerable amount of confusion and debate between and among various stakeholders within the mental health community (Bullock et al., 2000; Drake, 2000; Jacobson, 2001; Young & Ensing, 1999).

From examining the descriptions for each concept of recovery and existing literature covering these models, it appears that recovery has been defined differently by different

stakeholders, such as professional and service user groups, with very little known for the views of carers for recovery.

Producing a definition of recovery that is meaningful and valuable to service users, while being practical and achievable for clinicians and services, has yet to be resolved (Morrison et al., 2016). Therefore determining what is meant by recovery for each stakeholder is vital to work towards this consensus, however the concept of recovery has been less explored among healthcare professionals or carers for BD currently (Jacob et al., 2017).

Aims and Objectives

This review aims to advance the evidence on recovery for BD by systematically reviewing the available literature and evaluating a range of stakeholder views on recovery in BD. Evidence from this review aims to identify any gaps in knowledge for stakeholder views, or identify any discrepancies in views of recovery or experiences of health services. Results could then inform more appropriate interventions, by tailoring these to suit all stakeholder involved in recovery for BD.

The aims of this review were to; (1) Systematically identify qualitative studies examining views or opinions from a range of stakeholders on recovery for those with BD. (2) Assess the quality of the research. (3) To synthesise the findings using a thematic approach to explore how different stakeholders conceptualise recovery for those with BD and compare views to answer the main review question:

What are the different stakeholder views of recovery in BD?

Methods

Protocol and Registration

The protocol was pre-registered on PROSPERO 2020 CRD42020162011, available from: http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42020162011

The methods and reporting of the results for the current systematic review are written in accordance with Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines (Moher et al., 2010). A PRISMA checklist (Appendix B) was used to ensure all relevant details were included in this review.

Search Strategy and Data Sources

As this review aims to identify personal views and experiences of recovery for those with BD, the review will be focussed around four key areas using the PICoS (Tacconelli, 2010) criteria as follows:

- Population- Different stakeholder views (e.g. individuals or groups of people such as service user, professionals, carers, employers)
- Interest- Recovery
- Context- Bipolar disorder
- Study- Qualitative design for obtaining these views or experiences

Search terms were informed by similar reviews (Davenport et al., 2019; Pedley et al., 2018), terms found in Google Scholar search engine searches for recovery, BD or qualitative research and discussion with the research team. Additional terms were added based on pilot searches by refining the search strategy to maximise the inclusion of papers identified. Validity checks were also conducted by ensuring that number of key papers identified from initial searches, were then included during pilot searches.

Each component of the PICoS search terms was combined using Boolen operator ‘AND’, and search terms within each component using ‘OR’ (Table 1). The search was adapted for each individual database where required. The full search strategy can be found in Table 1.

Searches of four electronic databases (PsycINFO, Medline, CINAHL and Scopus) were carried out from the database inception to December 2019. An updated search of all four databases was competed in also March 2020, but found no further results. Some argue that one database, such as MEDLINE may be as sufficient as searching other databases, and capture almost all eligible studies (Rice et al., 2016), however others argue that additional databases may ensure all references for systematic reviews are retrieved (Bramer et al., 2017), and special topic databases should be added if the topic of the review directly touches the primary focus of a specialised subject database, (Bramer et al., 2017). To ensure all relevant references were retrieved two initial databases were used (MEDLINE and Scopus), along with specialised databases (CINAHL and PsycINFO) to add unique references due their focus on nursing, allied health, behavioural sciences and mental health topics.

Table 1

Parameters of review questions and search terms employed

Components	Search terms
Population	"staff" OR "worker" OR "care coordinator*" OR "personnel" OR "employee*" OR "clinician*" OR "professional*" OR "practitioner*" OR "therap*" OR "provider*" OR "leader*" OR "manager*" OR "physician*" OR "psychiatrist*" OR "doctor*" OR "nurs*" OR "occupational therap*" OR "social work*" OR "psychologi*" OR "peer support*" OR "vocational specialist*" OR "decision maker*" OR "carer" OR "famil*" OR "parent" OR "mother" OR "father" OR "sibling" OR "partner" OR "wife" OR "husband" OR "spouse" OR "service user" OR "patient" OR "consumer" OR "client" OR "personal" OR "employer"
AND	
Interest	recover*
AND	
Context	bipolar OR "manic depression"
AND	
Design	qualitative* OR "content analysis" OR interview OR "focus group*" OR discourse OR ethnograph* OR "grounded theory" OR narrative OR phenomenological OR vignette OR open-ended OR "semi structured" OR unstructured OR "in depth" OR "open question"

Eligibility Criteria

Inclusion Criteria

The current review aimed to identify studies reporting primary data, in peer reviewed articles for personal views or experiences of recovery in BD from the perspectives of multiple stakeholders. As a result, qualitative studies were required, where empirical data relating to recovery could be extracted. Mixed method studies were included, but only qualitative data were extracted for the purpose of the systematic review. Studies were included where participant samples contain at least 75% of stakeholders described in the search terms. Any systematic reviews were examined for any relevant primary studies for potential inclusion.

Exclusion Criteria.

Studies were not excluded based on publication date, or sample size or quality, however papers studies not published in English were excluded, along with any articles where a full text could not be obtained (either from searches or following contacting the lead author). Papers were also excluded if it was unclear who the sample was or if the study did not make specific reference to reporting on recovery for BD. Inclusion and exclusion criteria can be found in Table 2.

Table 2
Search strategy inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
English language text available	Not published in English
Peer reviewed articles only	Not accessible
Qualitative/ mixed methods studies	Studies that only include quantitative data
Studies focusing on either service user, carer/family, health professional or employer views.	No extractable data related to stakeholder perspectives of recovery in BD
Empirical data on recovery in BD	No empirical data (e.g. reviews/ book chapters)
	No primary data

Review Strategy

Stage 1- Screening.

All studies identified from search results were uploaded to Endnote to allow for duplications to be removed. Remaining studies were then exported into an Excel database.

All titles and abstracts were screened as the first stage of the review process, against the inclusion and exclusion criteria (Table 2). An independent reviewer (HB) conducted a 10% check of all titles and abstracts which were then compared for validity. Any disagreements between the two authors at this stage were resolved by consensus.

Stage 2- Full Text Review.

Full texts of studies included in stage 1 were then examined to exclude studies that do not meet the criteria. Reasons for exclusion at each stage were recorded using a PRISMA diagram (Figure 1). Again a 10% check was complete
d by a second author (HB) to check for validity at the full text stage and any inconsistencies at the full text stages were discussed between authors and resolved by consensus.

Stage 3- Reference Search.

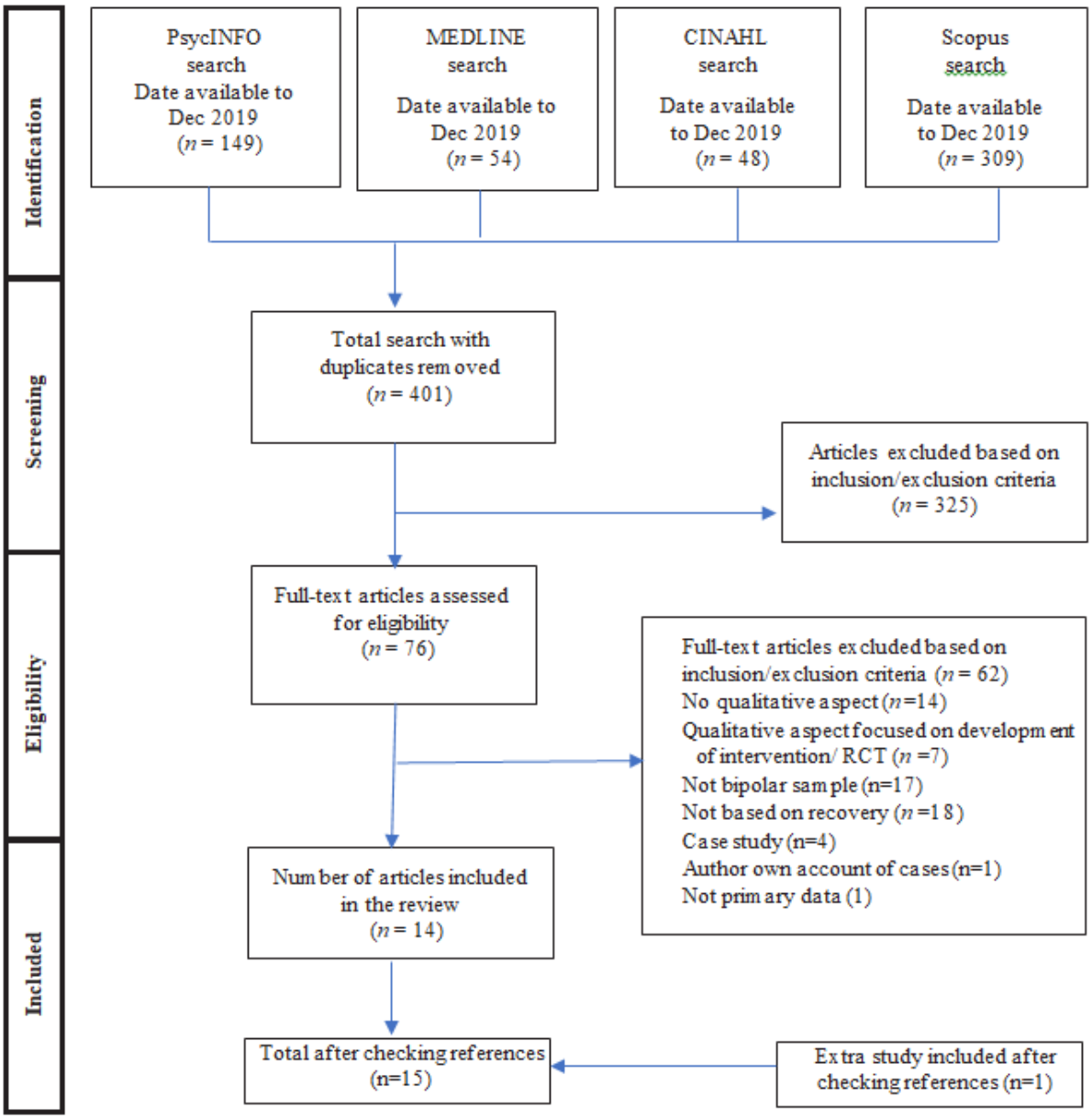
References from identified studies were manually searched for further relevant papers. Any identified from references were then also screened, initially at the title and abstract, then full text stages for eligibility against inclusion criteria.

Stage 4- Data Extraction

Following the search process, key information regarding the study characteristics from each identified study was imported into an Excel spreadsheet for the purpose of data extraction and quality appraisal. Results or findings sections from each identified paper were extracted and placed into NVivo 12 computer software (QSR International, 2008), ready for the synthesis process (see below).

Figure 1

PRISMA Flow Diagram



Quality Assessment

The Critical Appraisal Skills Programme for qualitative research (CASP, 2010) (Appendix C) was used to assess the quality of the identified studies. The CASP has been widely used in a number of qualitative syntheses (Chakrabarti, 2019; Coleman et al., 2017; Devereux-fitzgerald et al., 2016; Katsakou et al., 2019). The CASP tool assesses 10 key areas to help appraise qualitative research studies broadly in terms of rigor, credibility, and

relevance (Chenail, 2011) and helps determine what elements may be missing from a study. Data were extracted by reading through each paper and only scoring for each criteria if information included clearly demonstrated that criteria was met. If information was missing, or insufficient to be able to tell if these criteria were met, this item within the CASP was given a 0. An overall quality rating was given out of ten to each paper (Table 4).

A peer researcher double appraised a quarter (four) of the papers chosen at random. The peer researcher was blind to the authors' quality appraisal ratings. Ratings were then compared, and any differences were discussed and resolved through discussion, to ensure quality appraisal scores were correct. Quality scores were not used to exclude papers from the review, but to assess the quality of studies reviewed.

Synthesis Process

Extracted data from identified studies were subjected to a thematic synthesis to answer the systematic review question. As thematic synthesis was developed originally for systematic reviews that consider individuals' perspectives and experiences in order to address specific review questions (Barnett-Page & Thomas, 2009) this methodology was chosen as it was well suited to meeting the aims of this review.

Analysis of the results or findings sections from each paper was carried out with the use of NVivo 12 computer software (QSR International, 2008). The findings from each study were analysed by one research (DK) based on a process described by Thomas and Harden (2008) for collating, organising and coding data. Identified papers were read and re-read initially to fully immerse in the data (Thomas & Harden, 2008). All data collated was analysed and both author interpretations and direct quotes from study participants for each paper were given equal consideration during the analysis and coding.

Thematic synthesis is an inductive process involving the coding of data and generating descriptive and analytical themes. Thomas and Harden recommended for this to be carried out over three stages (Thomas & Harden, 2008).

Firstly, each line of text from the results and discussion of each study were individually coded according to their meaning and content for each participant perspective, to generate descriptive codes. Each line of text analysed produced at least one code.

The next recommended stage was to generate descriptive themes for each study by comparing and grouping together codes from the first stage. All descriptive themes were placed into an Excel spreadsheet together and compared for similarities and differences across studies, and different stakeholder views were highlighted and organised for comparison within each theme and were developed into analytical themes to gain evidence to answer the research question as a whole. Developing these analytical themes is a critical stage to further the content of primary studies, by using the descriptive themes to determine key messages. Themes could then be reviewed in relation to the review question.

The reviewer adopted a critical realist view (Shadish et al., 2001) during the synthesis process. This approach follows a view that despite all knowledge and experience developing in a real, knowable world, all decisions and interpretations during coding and development of themes are subject to the reviewer's own subjective, cultural and social experiences (Sayer, 2000). An iterative process of reflection and interpretation was used throughout whilst reviewing each theme, and across each study, in order to bear this in mind, and a reflective diary was kept as an audit trail for recording decisions made throughout the analysis process. Furthermore, to minimise any researcher bias within the coding framework, descriptive and analytical themes were discussed and refined by all the authors during regular meetings.

Results

Study Selection

Searches identified 560 studies initially which were reduced to 401 after removing duplications (Figure 1). Titles and abstracts were then screened for relevance against the inclusion and exclusion criteria. Following the exclusion of irrelevant titles and abstracts, 76

full text papers were screened against the inclusion and exclusion criteria. References from the final 14 studies were checked. One additional reference was identified from searching references lists of the final 14 studies to bring a total of 15 studies identified for the review. No additional papers were identified through alternative sources. Figure 1 outlines the stages for identifying relevant studies for the review using the PRISMA checklist (Moher et al., 2010).

Description of Studies

The aim of the review was to compare and contrast views for recovery in BD from different stakeholders. A summary of key characteristics of the 15 identified primary studies is provided in Table 3.

From analysing full texts from the 15 papers, 12 individual samples were identified. The three papers (Veseth et al., 2016, 2017, 2019) using the same sample, were from the four studies identified with professional participants, meaning only two samples of professionals were used in the review. In total, there were 494 participants, with samples ranging from three (Wharne, 2016) to 254 (Maassen, Regeer, Bunders, et al., 2018). Of the 494 participants there were 443 service users, 14 carers and 37 professionals. Ages from the samples ranged from 18 to 75 years, however two studies did not state ages of participants, one gave an average of 48.7 years across their study and one further study gave a range of ages being between 20s and 60s.

Of the 494 participants in the studies, 136 were female and 80 were male, the remainder of participant's genders were not declared (Table 3). Fernandez et al. (2014), focused exclusively on all female narratives. Participant ethnicity and diagnostic information were often not presented within papers.

Table 3
Descriptive statistics and demographic information

Authors, years and country	Stakeholder group	Participants (No. gender, and age)	Data collection	Data analysis	Author reported themes (recovery related)
1. Borg et al. (2013), Norway	Service user	N=13 (7 male, 6 female), age 27-65 years.	Semi- structured interviews	Thematic analysis	(1) Many types of work- finding meaning and a focus (2) Helpful roles and contexts- to be much more than a person with an illness (3) Making work possible- the role of supportive relationships and supportive medications (4) The cost of working too much- finding a meaningful and healthy balance.
2. Fernandez et al. (2014), Australia.	Service user	N= (10 female), age 29-68 years.	Semi- structured interviews	Constant comparison method	(1) Identity bound by the diagnostic label (2) multidimensional effects of the bipolar disorder identity (3) strategies for renegotiating identity.
3. Maassen et al. (2018), Netherlands.	Service user	N=35 (Phase 1), N=219 (Phase 2), gender and ages unknown	Mixed methods (Focus groups, Interviews)	Thematic analysis	(One from five themes discussed recovery) Recovery and recovery orientated care
4. Maassen et al. (2019), Netherlands.	Professional	N=18 (Phase 1) N=6 Phase 2), gender and ages unknown	Mixed methods (Focus groups, Interviews	Thematic analysis	(One from six themes discussed recovery) Recovery: reducing the impairments
5. Mansell et al. (2010), UK	Service user	N= 13 (9 female, 4 male), age 32- 61	Semi structured interviews	Interpretative Phenomenological Analysis	(1) Ambivalent approaches: monitoring against mania, medication, prior illness vs current wellness (2) Helpful approaches: understanding, life-style fundamentals, support and companionship, social change
6. Russell & Browne (2005), Australia	Service user	N=100 (63 female, 37 male), age 18-23	Semi- structured interviews and written documents	Thematic analysis	(1) Stay well concept (2) Strategies to stay well- acceptance of diagnosis, mindfulness, education, identify trigger factors, recognize warning signs, managing sleep and stress, make lifestyle changes, treatment, access support, stay well plans.
7. Stegink et al. (2015), Netherlands	Service user	N= 14 (12 female, 2 male), average age 48.7	Semi structured interviews	Grounded theory	(1) A safe and supportive environment (2) assistance in clarifying thoughts and feelings (3) Support in undertaking physical activities.
8. Todd et al. (2012), UK	Service user	N= 12 (7 male, 5 female), age 29- 56	Focus groups	Thematic analysis	(1) Recovery is not about being symptom free, (2) Recovery requires taking responsibility for your own wellness (3) Self-management: building on existing techniques (4) Overcoming barriers to recovery: negativity, stigma and taboo.

Table 3
Descriptive statistics and demographic information

Authors, years and country	Stakeholder group	Participants (No. gender, age and stakeholder)	Data collection	Data analysis	Author reported themes (recovery related)
9. Veseth et al. (2012), Norway	Service user	N= 13 (7 female, 6 male), age 27-65	Unstructured interviews	Hermeneutic phenomenological analysis	(1) handling ambivalence about letting go of manic states (2) finding something to hang on to when the world is spinning around (3) becoming aware of signals from self and others (4) finding ways of caring for oneself.
10. Veseth et al. (2016), Norway	Professional	N= 12 (7 male, 5 female), age 46-68	Semi structured interviews	Hermeneutic phenomenological analysis	(1) a puzzling given (2) the protagonist of the healing process (3) the heroic fighter does not always win.
11. Veseth et al. (2017), Norway	Professional	N= 12 (7 males, 5 females), age 46-68	Semi structured interviews	Thematic analysis	(1) establishing a sense of belonging (2) backing ongoing therapy (3) relational ripple effects.
12. Veseth et al. (2019), Norway	Professional	N= 12 (7 males, 5 females), age 46-68	Semi structured interviews	Thematic analysis	(1) the bedrock of therapy (2) an imperfect answer and a dangerous tool (3) the hallmark of insight (4) negotiating medicine, negotiating meaning.
13. Warwick et al. (2019), UK	Service user	N=12 (6 male, 6 female), age 32-63 years	Semi- structured interviews	Grounded theory	(1) Support (2) Recognition of the problem (3) Believing things can change and not giving up (4) Instinctive curiosity (5) Medication (6) Psychological therapy (7) Becoming the director of your own life (8) Changing how I think (9) Accepting who I am and how I feel (10) Looking after me
14. Wharne (2016), UK	2 service users, 1 professional	N= 3 (2 female, 1 male), age 20s-60s,	Semi- structured interviews	Hermeneutic phenomenological analysis	(1) Self- experiment while feeling left out (2) Being watched and challenged (3) Becoming autonomous, being responsible
15. Yuen et al. (2019), China	Carers	N=14 (11 female, 3 male), ages30-75	Semi- structured interviews	Thematic analysis	(1) Understanding the concept of recovery from the perspective of family caregivers (2) their experience of interactions with peer supporters (3) perception of the impact of peer support services on individuals with BD and on caregiving journey.

Nine studies recruited service users with a diagnosis of BD (Borg et al., 2013; Fernandez et al., 2014; Maassen, Regeer, Regeer, et al., 2018; Mansell et al., 2010; Russell & Browne, 2005; Stegink et al., 2015; Todd et al., 2012; Veseth et al., 2012; Warwick et al., 2019), four studies recruited mental health professionals (Maassen et al., 2019; Veseth et al., 2016, 2017, 2019), and one study recruited a mixture of service users and a professional (Wharne, 2016). Mental health professionals recruited included therapists, clinical psychologists, mental health nurses, and psychiatrists. Only one study recruited carers of family members with BD (Yuen et al., 2019), with family members ranging from mothers, husbands, wives, sisters, daughters and sister in laws.

Eleven studies used semi-structured or open-ended interviews (Borg et al., 2013; Fernandez et al., 2014; Mansell et al., 2010; Stegink et al., 2015; Veseth et al., 2012, 2016, 2017, 2019; Warwick et al., 2019; Wharne, 2016; Yuen et al., 2019), with another two using a mixture of focus groups and interviews (Maassen et al., 2019; Maassen, Regeer, Bunders, et al., 2018), one used a mixture of semi-structured interviews and written documents (Russell & Browne, 2005), and one study used focus groups only (Todd et al., 2012).

Thematic analysis was used as the qualitative methodology for eight studies (Borg et al., 2013; Maassen et al., 2019; Maassen, Regeer, Bunders, et al., 2018; Russell & Browne, 2005; Todd et al., 2012; Veseth et al., 2017, 2019; Yuen et al., 2019), three studies analysing results using hermeneutic phenomenological analysis (Veseth et al., 2012, 2016; Wharne, 2016), two analysed data using grounded theory (Stegink et al., 2015; Warwick et al., 2019), one analysed data using constant comparison method (Fernandez et al., 2014) and the remaining study analysing results using interpretive phenomenological approach (Mansell et al., 2010).

Twelve studies focused primarily on recovery for BD (Borg et al., 2013; Mansell et al., 2010; Russell & Browne, 2005; Stegink et al., 2015; Todd et al., 2012; Veseth et al., 2012, 2016, 2017, 2019; Warwick et al., 2019; Wharne, 2016; Yuen et al., 2019), two studies focused on creating research agendas for BD (Maassen et al., 2019; Maassen, Regeer, Bunders, et al., 2018), from which recovery became a theme highlighted and could be

extracted for the purposes of this review. One further study aimed to explore recovery, however during the analysis authors described that recovery was not highlighted as a key point for participants' discussion (Fernandez et al., 2014). When explored further, the participants did discuss key findings relating to personal recovery that were also discussed in other studies included in this review, such as focusing on BD and identity, and so was included in this review, following agreement with the wider research team.

All but one study (Russell & Browne, 2005) was published during the last decade. Studies of service user and professional views were conducted across four countries, Norway, Australia, Netherlands, and UK, with five out of 15 studies conducted in Norway, representing the growing recovery literature into BD from this country. However the single study evaluating carers' views was undertaken in China, which may limit the transferability of the findings to other cultural settings, such as the service user and professional views from this systematic review.

Overview of Quality Assessment

From the quality appraisal results (Table 4), all studies scored between 7 and 10 indicating at least adequate quality on CASP, and therefore poor quality research did not need to be taken into account as a potential limitation when compared to other findings within the review. Lower scores were due to insufficient detail, rather than information missing completely.

All papers other than Yuen et al., (2019) failed to report whether the relationship between the researcher and participants was considered. This is vital in qualitative research in order for the authors to acknowledge the impact that their own beliefs, judgements and practices can have during the research processes. This may have impacted on how final results were collated and/or analysed, and individual study results may vary.

Furthermore 5 papers also did not sufficiently report whether ethical issues had been taken into consideration (Borg et al., 2013; Fernandez et al., 2014; Maassen et al., 2018; Maassen et al., 2019; and Wharne (2016), which can make it unclear if any ethical issues

were raised during these studies. This may be particularly useful to consider for any possible conflict of interest during participant involvement, or whether participants felt they were able to discuss ideas openly without concern for this impacting on their healthcare received or professional roles being affected.

Table 4
CASP Quality Appraisal Scores

Authors, years and country	Is there a clear statement of aims?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Total quality rating score
1. Borg et al. (2013),	✓	✓	✓	✓	✓	X	X	✓	X	✓	7
2. Fernandez et al. (2014)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8
3. Maassen et al. (2018)	✓	✓	X	✓	✓	X	X	✓	✓	✓	7
4. Maassen et al. (2019)	✓	✓	X	✓	✓	X	X	✓	✓	✓	7
5. Mansell et al. (2010)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
6. Russell & Browne (2005)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
7. Stegink et al. (2015)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
8. Todd et al. (2012)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
9. Veseth et al. (2012)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
10. Veseth et al. (2016)	✓	✓	✓	✓	✓	X		✓	✓	✓	8
11. Veseth et al. (2017)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
12. Veseth et al. (2019)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
13. Warwick et al. (2019)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9
14. Wharne (2016)	✓	✓	✓	X	✓	X	X	✓	✓	✓	7
15. Yuen et al. (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10

Thematic Synthesis Findings

Findings from the systematic review identified seven themes across the 15 studies reviewed. On average, 10.7 studies discussed each theme; however medication was only discussed in six of the identified studies. This appears initially to be due the majority of studies involving service user participants (10), and only four studies with participants discussed their views on medication for recovery.

The most salient theme across studies was increased understanding, which featured in 13 studies. The theme identity featured amongst all studies involving service users, initially highlighting the importance of identity for service users; yet this was not discussed in the one study with carers, and only one professional study (Veseth et al 2017).

From individual service user studies, the minimum number of themes discussed was three (Fernandez et al., 2014), with one study (Borg et al., 2013) discussing all seven themes. From professional studies, at least one professional study featured in each theme, with the theme strategies, being mentioned by all four professional studies, but was not mentioned from the mixed professional and service user study. One study discussed two out of seven themes (Maassen et al., 2019), with a further study mentioning six out of seven themes (Veseth et al., 2017). However it is important to note that only one study in the review was conducted with carers, which discussed four identified themes, increased understanding, social acceptance, support and strategies, which may initially demonstrate the roles carers play for their own understanding of BD, and how they can support a service user they care for.

Themes below are presented in terms of the key similarities and differences, and between stakeholder views.

Table 5
Individual Study Contribution to Themes

	Participant group	Theme 1: Increased Understanding	Theme 2: Social Acceptance	Theme 3: Empowerment and Responsibility	Theme 4: Support	Theme 5: Identity	Theme 6: Strategies	Theme 7: Medication
1. Borg et al. (2013)	Service user	✓	✓	✓	✓	✓	✓	✓
2. Fernandez et al. (2014)	Service user	✓		✓		✓		
3. Maassen et al. (2018)	Service user		✓	✓	✓	✓		
4. Maassen et al. (2019)	Professionals		✓				✓	
5. Mansell et al. (2010)	Service user	✓	✓		✓	✓	✓	✓
6. Russell & Browne (2005)	Service user	✓	✓	✓	✓	✓	✓	✓
7. Stegink et al. (2015)	Service user	✓	✓	✓	✓	✓	✓	
8. Todd et al. (2012)	Service user	✓	✓	✓	✓	✓	✓	
9. Veseth et al. (2012)	Service user	✓			✓	✓	✓	
10. Veseth et al. (2016)	Professionals	✓		✓	✓		✓	✓
11. Veseth et al. (2017)	Professionals	✓	✓	✓	✓	✓	✓	
12. Veseth et al. (2019)	Professionals	✓		✓			✓	✓
13. Warwick et al. (2019)	Service user	✓	✓	✓	✓	✓	✓	✓
14. Wharne (2016)	Service users and professional	✓		✓	✓	✓		
15. Yuen et al. (2019)	Carers	✓	✓		✓		✓	
Number of studies in each theme		13	10	11	12	11	12	6

Theme 1- Increasing Understanding

Twelve papers provided data for the theme of increasing understanding (Table 5). Service users and professionals preferred psychoeducation to increase their understanding of BD. However whilst service users applied this knowledge to their own experiences and provided optimism for their recovery, carers placed more emphasis on learning from others experiences and professionals focussed more on symptom management.

Resources for Increasing Understanding

Accepting a diagnosis of BD was described as a “pivotal step” in recovery studies for service users (Mansell et al., 2010, p207), and the point where many service users wanted to increase their understanding of BD (Russell & Browne, 2005; Warwick et al., 2019).

Service users, professionals and carers coalesced in their views on the importance of resources in increasing understanding. Service users and professionals prioritised psychoeducation whereas carers placed more emphasis on shared experiences in included studies.

Service users reported using a wide variety of resources for obtaining information from seeking information from others such as healthcare professionals and support groups to accessing information themselves through books, academic resources like NICE guidelines and seminars. Professionals also valued providing information through psychoeducation, describing this as “perhaps the most valued [activity] we’re doing”, which enabled families and individuals “to become empowered and responsible for their own recovery” (Veseth, 2017, p5).

Carers however described how sharing experiences rather than psychoeducation, enabled them to make sense of BD, provided hope and allowed an adjustment in their expectations, appreciation and understanding of their family members.

> “I have greater hope than before, when I could only see the negative aspects” (Yuen et al., 2019, p309).

Benefits of Increased Understanding

By searching for information, service users understood the link between their thoughts, feelings and about their mood. This gave a greater understanding of their own diagnosis and the "importance of learning about their own individual response to the illness" (Russell & Brown, 2005, p190). Professionals were found to help by providing methods to increase chance of managing episodes and more regulated moods (Wharne, 2016).Noticing unhelpful thinking patterns were viewed as an important skill that had developed in their recovery process where "everything started to make sense" (Warwick et al., 2019, p373).

Professionals agreed with service users' views, believing that service users themselves needed to acknowledge their diagnosis, understand symptoms of severe mental distress. However views from the two studies on professional views for this theme focussed on a clinical, medicalised approach to understanding BD, which linked with ideas of insight into illness and use medication regularly to manage symptoms (Veseth et al., 2019).

The Possibility of Recovery

A key point of divergence in identified stakeholder narratives was the perceived possibility of recovery. Service users had more optimistic reviews in this regard when compared to carers and professionals. Carers and professionals, who described recovery as not possible for everyone with BD. Some caregivers were doubtful about whether their family members would recover to the extent of being once again the person they were before the illness.

"I do not thoughtlessly believe that everyone can get well" (Yuen et al., 2019, p309).

"It's about accepting that you have a chronic illness... because it is hard to get by without medication when you're bipolar." (Veseth, et al., 2019, p70).

However service users described this as being possible, once measures, such as avoiding stressful situations and utilising strategies are put into place. "I realise that I can still deal with quite difficult situations and the illness has not come back" (Mansell et al., 2010, 207). Some service users also criticised the information they found, often disagreeing with it

(Mansell et al., 2010), stating that generalisations were made in NICE guidelines, that did not reflect the individualised nature of BD. Some service users developed their own strategies for remaining well while others described the importance of using knowledge to "learn to monitor ourselves and accept what our bodies can do" (Russell & Browne, 2005, p190).

Theme 2- Social Acceptance

Ten papers within the review (Table 5) identified stigma, difficulties in relation to social integration and the importance of social acceptance as key features of recovery from BD. The importance of social acceptance in terms of recovery was highlighted as important by service users, carers and professionals.

Stigma

Service users reported difficulties with stigma stating that BD was "perceived negatively within the community" (Russell & Browne, 2005, p189), and how this "negativity from the public, even family and friends, became part of their identity and was reinforced by services" (Todd et al., 2012, p120).

Carers did not make any comments around stigma, however professionals agreed with service user views that further research is needed to "increase knowledge in society and decrease stigma", as the term BD is often misunderstood (Maassen et al., 2019, p4). However, carer and professional studies did not report how stigma may impact on service users with BD.

Social Integration

Both carers and service users described views related to the importance of service users having a connection in society and sustaining a job for their recovery. For carers, recovery meant it was important for relatives to be able to have a connection with society. Some carers hoped family members would be "able to sustain a job… to be able to support themselves independently as a sign that they had recovered" (Yuen et al., 2019, p308).

Other carers mentioned relatives “doing activities they enjoy, having people around them and in society or being able to establish relationships, rather than feel different to others” (Yuen et al., 2019, p307). This was similar to service users’ views which described that “working gave them a socially accepted and valued role” (Maassen, Regeer, Bunders, et al., 2018, p14). Returning to work was important for social acceptance and social recovery but described as difficult due to stress this brings. “Dealing with the ordinary challenges of a workplace, as well as the presence of stress that maybe triggers one’s problems” (Borg et al., 2013, p334).

Only one professional study (Veseth,et al., 2017) reported social acceptance, which described recovery as “inextricably linked to processes of finding ones place in the local community” (Veseth et al., 2017, p4). Professionals also warned against excluding people with BD from the family as this can be damaging for recovery “he had more or less become a nonperson to them, and unfortunately that did not break off along with his recovery” (Veseth et al., 2017, p4).

Theme 3- Empowerment and Responsibility

Self-management and being able to make choices was described as a crucial part of recovery for service users were key themes for empowerment. However service users’ and professionals’ views on medication use and who should be responsible for making decisions for medication use differed, with professionals reporting their role was to advise on or encourage medication use.

Two service user studies (Warwick et al., 2019; Wharne, 2016) heavily emphasised the importance of service users being able to take control of their own recovery, which was related to promoting views of personal recovery. However the study for carers’ views did not contribute towards to this theme.

Responsibility for Decisions

There were identifiable differences in stakeholder accounts in terms of who should have responsibility for decision making in relation to recovery. Service users expressed a desire for autonomy in relation to decision making but professionals appeared to find this difficult to implement in practice. Service users described "developing a sense of self-efficacy enabling them to shift from being a recipient, to feeling and being in charge of their recovery and "needing to find their own path to recovery" (Warwick et al., 2019, p373).

Despite professionals accepting service users' opinions, professionals however described that they continued to encourage the use of medication during future appointments. One professional reported "he can make contact at any time. And I'm there with my prescription block if he should change his mind" (Veseth et al., 2019, p71). Professionals also reported that it was difficult to work with service users who refused recommended medication (Veseth et al., 2019). These views were reflected also in service user views, where service users described "that they were not involved in decisions … however, [later moved] from a position in which they were not involved, to an experience of discussion and negotiation" (Wharne, 2016, p537). Another service user described professionals as "offering instant solutions... [rather than] making an effort to enhance the [service users'] own abilities…[and] self-management skills" (Stegink et al., 2015, p294).

Service user views for recovery were emphasised when service users described that they did not want to be cured from BD, instead "becoming empowered and in control of their lives was central to recovery" (Warwick et al., 2019, p373). Some sought to find out more about alternative treatment options through their own research or from others' experiences, which "led to them actively searching beyond the initial medical guidance, providing alternative treatments options" (Warwick et al., 2019, p375).

Positive Risk Taking

Service users described feeling that it was their right as service users to take risks, particularly for stopping treatment to see if they could self-manage, but often "felt watched in

the sense that their choices were subject to the scrutiny of others" rather than supported for this by professionals (Wharne, 2016, p537). Within the same study, a professional reported wanted to support positive risk taking but felt impeded by organisation culture and fears around scrutiny from others (Wharne, 2016). Professionals therefore were unable to 'handover' all responsibility. Further issues arose around therapeutic relationships, where service users described professionals talking with relatives rather themselves to gain information on their mental state, and were too quick to assume they were unwell if relatives believed there had been a recent change to their mood.

One study even suggested that "mental health services could be detrimental to their recovery as they do not encourage self-management or therapeutic risk taking" (Todd et al., 2012, p119). Furthermore, service users sometimes instead went against professional advice, and despite initially having taken medication, they later experienced or were put off by potential side effects (Warwick et al., 2019; Wharne, 2016).

Theme 4- Support

Twelve papers included in the review referred to a range of support networks that were relied upon by service users for working towards recovery (Table 5). Service users and professional both highlighted the input from lay networks in addition to professional input.

Monitoring Early Warning Signs

Service users' views were mixed on who would monitor early warning signs for changes in mood. Whilst some service users described monitoring early warning signs themselves, others highlighted the role of family, friends or professionals were able to "recognise their early warning signs… observing small changes in their physical, mental and emotional status" (Russell & Browne, 2005, p191), when individuals were unable to notice early warning signs or for reassurance when they felt they coped well (Warwick et al., 2019), as self-monitoring "often lead to rumination" (Mansell, 2010, p205).

Professionals described that it is “never enough” for just a professional to support someone with BD, and a solid foundation of social support is “particularly crucial” for belonging and connecting with others outside the mental health system (Veseth et al., 2017, p3).

Professionals were found useful by service users for providing advice, however, it was felt that these signs described came too late, and service users described preferring to monitor much earlier signs than what professionals advised. However, service users also valued when others such as family and professionals intervened when they started to become ‘a little high’ to prevent the further escalation of symptoms (Mansell et al., 2010).

Sources of Support

Close family members were implicated by both service users and professionals as important to recovery. Service users made reference to supportive partners for “providing encouragement and practically helpful for taking on extra tasks at home, such as childcare” (Borg et al., 2013, p332). Professionals also described this support, acknowledging that families assisted service users by administering medication at home, or providing practical support and trust (Veseth et al., 2017).

There were more mixed views in terms of wider support from lay networks. Both carers and service users described the benefits of support groups which provided companionship for service users, along with providing further resources and avenues of support. However service users also argued that support groups enabled people to define themselves by their illness (Mansell et al., 2010). Another study described service users preferring to join local community groups such as writing, book, music or sport clubs, but rarely mental health support groups, which “did not encourage you to get on with your life and get back into work” (Russell & Browne, 2005, p191). One professional study also made reference to the importance of “having connections from being part of a faith community” (Veseth et al., 2017, p4), however no other stakeholders made reference to the faith community.

Managers and colleagues at work were “vital for encouragement and support when returning to work” for service users (Borg et al., 2013, p331), and could offer practical assistance like flexible hours or tasks, and frequent breaks when needed. However this support was not mentioned in professional or carer studies.

Theme 5- Identity

Several service user studies referred to how they came to understand their BD, and how this diagnosis may impact on how they view themselves as a person (Table 5), Professionals from one paper only (Veseth et al., 2017) discussed the topic of identity for those with BD. Carers’ views did not feature within this theme.

BD as a Separate Identity

Some service users described the importance of not being defining by their illness (Mansell et al., 2010, p202) and reported they “felt more able to cope, by being able to take control of their own lives, and separate themselves from their diagnosis” (Mansell et al., 2010, p194).

“Bipolar is what I have, it is not who I am” (Fernandez et al., 2014, p897).

From not being defined by a diagnosis of mental illness, service users could ‘feel normal’ as someone other than having a diagnosis of BD (Borg et al., 2013), learn more about and accept this separate, new identity (Fernandez et al., 2014), view a diagnosis as describing the illness, not themselves (Russell & Browne, 2005), and achieve recovery by seeing beyond the illness (Todd et al., 2012). One study described making sense of BD as having a different side to their identity, with their BD being inconsistent to themselves, making choices that later did not make sense to them (Wharne, 2016).

BD as a New Identity

Some service users experienced difficulties in conceptualising how a mental illness can become part of, or an aspect of someone (Wharne, 2016) and service users described a

loss of identity and sense of self whilst struggling with attempts to separate themselves from the illness, due to the need to constantly monitor for high and low moods (Warwick et al., 2019).

"The illness isn't all of me, but at times it feels like it" (Mansell et al., 2010, p206) and that "symptoms, diagnosis, medications, and psychotherapy challenged identity" (Mansell et al., 2010, p196).

Instead some service users described developing pre and post diagnostic identities (Fernandez et al., 2014), whereby these service users accepted that their BD was now a condition they expected to have for the rest of their life (Mansell et al., 2010). However, views were mixed amongst service users about new identities as some reported their new identity as not always being the person that they always wanted to be (Wharne, 2016). Some struggled at times with self-acceptance of being chronically ill and in need of medication (Maassen, Regeer, Bunders, et al., 2018), whilst another described preferring the person they are now, who finds experiences in life to be sharper, more vivid and better (Mansell et al., 2010).

Only one paper from professionals (Veseth et al., 2017) discussed identity. Professionals from this study described this value of "meaningful activities and employment to help build connections into the community" (Veseth et al., 2017, p4). This enabled someone with a diagnosis of BD to "find some meaning in life and coherence as being more important than symptoms or distress" (Veseth et al., 2017, p4).

Both professionals and service users thought employment and valued activities played an important part in maintaining a positive sense of identity.

> "the participants referred to work as a valuable and often stabilizing arena for belonging somewhere outside their house and family where they could be someone: a teacher, an industrial worker, a social worker or a service assistant" (Borg et al., 2013, p331).

> "The experience of being seen as 'normal' could be about the pleasure of having an ordinary job, creating a job out of a hobby or simply experiencing the feeling of being needed and contributing" (Borg et al, 2013, p330).

Work and valued activities contributed to a positive sense of identity through shaping how they viewed by others and providing a feelings of self-worth and competency. Employment gave service users an opportunity to take pleasure in having normal job, the feeling of being needed and contributing, and functioning like most people with or without an identity of BD. These views were reflected by professionals who described work as being important for their "feeling of competency and self-worth" (Veseth et al., 2017, p4).

Theme 6- Strategies that Promoted Recovery

Monitoring Early Signs and Symptoms

Monitoring early signs of relapse was a vital strategy used in all studies involving service users' views of recovery. Identifying triggers, early warning signs and strategies, for themselves and others were reported as key in ensure service users avoided episodes of illness (Russell & Browne, 2005). However, despite these being strategies that professionals could become involved in supporting; no professional studies mentioned these approaches.

Professionals however argued that more research was needed "to contribute to reducing impairments [and] to gain knowledge on effective self-management strategies" (Maassen et al., 2019, p4), which highlighted the possible lack of awareness of numerous strategies reported by service user narratives.

Individualised Strategies

Service users described many years of great effort in finding ways to live well with BD (Borg et al., 2013; Veseth et al., 2012) and as such had developed personalised strategies for coping with everyday life during recovery. "Many had developed idiosyncratic

strategies for coping with the challenges posed by living with a BD, using their experiences of depression, hypomania, or mania to acquire different ways of handling everyday life burdened with periods of intense ups and downs" (Veseth et al., 2012, p124).

For service users, there was often a period of "trial and error in which participants learnt what strategies worked for them and what did not work" (Russell & Browne, 2005, p190), despite either "substantial effort or going against professional advice" (Warwick et al., 2019, p373).

Service users described "a number of strategies that had developed over time for staying well" (Todd, et al., 2012, p119). Some described the importance of healthy eating and physical activity (Mansell et al., 2010; Russell & Browne, 2005), using rational, positive thinking, and focussing on future (Borg et al., 2013), religion, self-care and relaxation (Veseth et al., 2012), a regular sleep routine (Borg et al., 2013; Mansell et al., 2010; Russell & Browne, 2005), managing stress and avoiding caffeine or alcohol (Borg et al., 2013; Russell & Browne, 2005), spending time with loved ones, having quiet times and laughing (Russell & Browne, 2005). Carers or professionals did not mention strategies described by service users.

Reflecting and Finding Balance

A common narrative from service users was about constant balance in every aspect of their lives. "in addition to eating and sleeping well, participants stressed the importance of reducing their workload in order to better facilitate a 'work-home, work-social life balance', which includes the cultivation and strengthening of relationships in all areas of their lives" (Mansell, et al., 2010, p208). Some set limits on what they can be involved in to reduce the demands and expectations of everyday life (Veseth et al., 2012) and reducing "the number of tasks in work to facilitate a better work-life balance" (Mansell et al., 2010, p208). However some described being more cautious, and not becoming fully involved in situations which could become detrimental to well-being. "…there is always the worry that it might go a little too far and I'll go manic" (Mansell et al., 2010, p204).

These strategies for maintaining balance follow the personal recovery model as service users described using strategies which enabled “becoming empowered and in control of their lives” (Warwick et al., 2019, p373). Furthermore some service users described strategies as being able to move from “prior illness to current wellness” (Mansell et al., 2010, p210).

Doing a minimal level of physical activity was viewed as important in maintaining control and preventing depression and contributing to the recovery process. Creating and maintaining balance in activities assisted with effective mood management and improved motivation (Warwick et al., 2019) with everyday activities offering distraction, a sense of accomplishment and created opportunities to push past boundaries (Stegink et al., 2015). A balance of meaningful activities combined with good sleep, were described to be the best medication (Borg et al., 2013). This point may emphasise a different approach to professional views which described the “need to have some goals in your life. Eating pills and spending your days at a psychiatrist’s couch is not an all-time high. So you want to be doing other things as well” (Veseth et al., 2017, p3). Similar views can indicate a clinical view for recovery, whereby professionals may understand the importance of activities for service users; however this would be in addition to clinical approaches such as medication or therapy.

The one study from carers’ views described the importance of peer support services as “being helpful for service users to encourage activity levels and leave the home if they had no friends or social support in community” (Yuen et al., 2019, p308). However, in contrast, professionals highlighted how a service users’ “own determination, persistence and exertion was crucial to recovery” (Veseth et al., 2016, p443), rather than input or support from others.

Benefits of Work

Both professionals and service users described using work as a strategy for maintaining wellness, but described as being used in different ways. Professionals agreed

with service users views that although work could be challenging at times, this can also have many positive benefits, such as “improving service users economic conditions, social status and being important for feelings of competency and self-worth, providing with necessary structure and social rhythm to their everyday lives” (Veseth et al., 2017, p4). Some service users also described work as being able to help them remain motivated, and that using their intellect and cognitive capacity allowed them to be challenged in work, along with having structure in their day and helped cope with BD symptoms (Borg et al., 2013).

Service users (Borg et al., 2013) emphasised the importance of exploring ways of living with the coexisting of work/activities and persistent symptoms of BD. Finding a balance between rest and activity, being alone or being sociable was discussed and often involved trial and error when it came to coping with the impact of mood swings on their daily life (Borg et al., 2013).

Theme 7- Medication

There were mixed views on the role of medication in recovery amongst service user narratives in included studies. Professionals described medication as key for managing bipolar symptoms, however professional views for this theme heavily focussed on one paper which examined professional views on medication. Carers did not make any reference to medication.

Professionals in one study described medication to be the most important strategy for when becoming manic, but described service users as often being unaware when they are becoming unwell. Encouraging medication adherence was difficult as this can be “very challenging for service users to do over time” due to contrasting service user views of medication (Veseth et al., 2019, p70).

> “I really can say, it is the most effective means we’ve got to stabilise these fluctuations… getting [them] to use that medicine was the most important thing” (Veseth et al., 2019, p70).

> “medication was one of very few means the therapists knew they could rely on when battling such destructive symptomatology” (Veseth et al., 2019, p69).

A key point of divergence was that professionals viewed medication as a primary treatment strategy at least for stabilisation but this didn’t appear to have the same salience for service users.

“It is 20 years since I have seen a psychiatrist and other than being told by my local GP that I should continue taking lithium each day as a precaution, I have not sought nor, in my opinion needed, any medical treatment.” (Russell & Browne, 2005, p190).

Service users foregrounded self-management strategies and viewed medication as something that should support engagement with employment and valued activities and deemed professional views on medication was “bad advice” (Russell & Browne, 2005, p190).

> “medication must support the working role, rather than be a barrier” (Borg et al., 2013, p331).

One study reported service users using complimentary therapies in addition to medication, such as psychological treatments, exercise or traditional medicines “Many participants used both prescribed medication and complementary therapies. The most commonly cited complementary treatments were cognitive behavioural therapy (CBT), nutritional supplements, naturopathy, psychotherapy, traditional Chinese medicine, massage, tai chi, meditation and yoga” (Russell & Browne, 2005, p191). However, professionals made no mention of alternatives to medication.

Service user views on medication were mixed with some service users experiencing positive benefits, and some using the lowest dose possible, but felt concerned about discontinuing medication. Some chose to come off medication altogether, describing

recovery as starting once medication had stopped “true recovery started when I gave up the meds” (Warwick et al., 2019, p369).

For service users taking medication, some described being uncertain whether coming off medication would make them better or worse or expressed “a desire to come off medication one day” (Mansell et al., 2010, p205) and many also believed relapse was just around the corner, and coming off medication would likely result in a relapse (Mansell et al., 2010, p205).

Service users however often felt medication was not personalised and “health care professionals often advised people with bipolar mood disorder to take their medication and forget about the illness’” (Russell & Browne, 2005, p190).

Trial and error to find the right medication was mentioned by service users (Borg et al., 2010), with some discussing “the long journey in finding the right medication, which was understood as “not a cure [but to] stabilise” (Warwick et al., 2019, p373). Professionals also acknowledged the same process of trial and error that service users described with medication. Professionals described this as a “sometimes lengthy and wearisome process….much like an open experiment, they collaboratively needed to explore how different pharmaceuticals, doses, or combinations of medicines would affect each person’s everyday life” (Veseth et al., 2019, p69).

Discussion

A thematic analysis of included studies as conducted to identify potential differences between different stakeholder views on recovery for BD. Despite the skewed representation towards service user narratives from the identified primary studies, some key differences in experiences were apparent from the review, and many themes supported views from existing literature on recovery.

Several themes identified matched those described within the CHIME framework (Leamy et al., 2011), such as connectedness (Social acceptance), identity and

empowerment. Despite not being identified as separate themes, the remaining processes from CHIME, hope and optimism and meaning in life were frequently referred to throughout findings from primary studies and subsequently identified themes from this review.

Service users described a process similar to connectedness, with social integration and social acceptance as key for recovery. Like service users, carers described connectedness for service users through being integrated into a community, sustaining a job, relationships and doing pleasurable activities as important for recovery (Borg et al., 2013, Yuen et al., 2019). One professional also described the importance of finding their place in a local community, however professional views were limited to this one professional study. These initial views relate to the personal model of recovery, particularly from service users and carers.

Identity also featured strongly from service user narratives in this review. Recovery and personal identity are found to be dominated by service users in existing literature and is often defined in terms of an ongoing process requiring a change in attitudes and values (Reeper & Perkins, 2003).

Similar ongoing changes to identity as described in both the CHIME framework, and also Cooke et al. (2010), were found from service users accepting their diagnosis of BD and redefining the sense of self to include their BD. Many service users developed new methods or strategies to move forward and enable a fulfilling life alongside having this condition. This is similar to the conversion from coping to healing process described by Fisher (2000), where service users no longer feel they need to cope with symptoms of BD and instead follow the process of accepting these symptoms as part of their diagnosis as part of their recovery. Many changes were made by service users to make an adjustment for their BD, such as reducing stress and pressures from life or avoided situations. These changes are like those described by Slade (2010), where changes to goals, values, attitudes, and roles can assist towards a satisfactory, hopeful, and productive way of life, whilst accepting possible limitations BD may bring. This importance service users placed on acceptance of BD rather than wanting a cure was evident throughout themes in this review. These all also

provided evidence that service users placed value on thinking outside the traditional chronic illness of BD and provided further evidence for service users following the personal recovery model. Research into recovery for psychosis found that service users who experienced an increase in personal recovery approaches also felt empowered for their own responsibility for recovery (O'Keeffe et al., 2018). These findings also relate to service users' narratives which described wanting to increase their own understanding and feel empowered and in control of their own lives. However personal recovery also identifies with learning and growth (Fisher, 2000; Whitehill, 2003), and has been described as an ongoing process of personal discovery (Kelly & Gamble, 2005). Many resources were described by service users to increase their knowledge and understanding of BD, especially earlier on to help understand their diagnosis. Carers also valued an increase in knowledge to gain further understand of their relatives' experiences. Like service users, this increased knowledge allowing for an adjustment in their expectations and appreciation for family members.

Close family members were described as a source of support and assistance with monitoring early signs of relapse. Carers' views of recovery were limited, for this review, featuring 14 participants from one study. Carers' views appeared to be closely aligned to those of service users in some areas including wanting to empower service users and allow them to become self-sufficient. This often involves being integrated within a local community through meaningful activities or employment. However, carers' limited views of recovery also appeared to be significantly different to those described by service users in other areas. Carers described service users as recovered if they were able to maintain longer emotionally stable periods without medication (Yuen et al., 2019). This view would be more in line with a traditional, clinical approach to recovery.

Professionals in included studies demonstrated limited awareness of self-management strategies or complementary treatments which were foregrounded by service users. This relates to previous literature which has found how mental health professionals have been unfamiliar with the role of hope for the future in recovery, and instead have

placed preference on more clinical recovery focussed outcome measures with BD being a lifelong condition involving symptom management and compliance with treatment (Bedregal et al., 2006). The most prominent themes however within the synthesis, and central to the clinical and personal models of recovery, were the themes around strategies and medication. Healthcare professionals are required to follow clinically driven NICE guidelines, which were criticised by service users for being too generic and not reflecting the individual nature of BD. This approach was also reflected in professionals' views that service users needed to understand and monitor symptoms of severe mental distress and use medication regularly to recover. Professional views on the preference of clinical recovery featured much more within the medication theme and described how medication was one of few means available for symptomology and enabled other strategies to work. Professionals appeared to rely heavily on medication, and adherence to medication from service users. Previous studies have found similar views from professionals which is believed to be as a result of the clinical training that healthcare professionals have undertaken, covering dysfunction, symptomatology and risk (Davidson & Roe, 2007), associated with clinical model of recovery. These all indicate a preference for following the clinical recovery model and directly contrasts the personal recovery model (Slade et al., 2012), service users describe from the primary studies identified.

Service user views on medication however were mixed, with evidence showing that reductions in medication, discontinuing altogether and complimentary therapies were often considered, as well as adhering to medication. Where medication was described as a strategy used, this was accepted alongside many other strategies such as education, sleep, and healthy eating and exercise. Medication was also described as needing to allow them to function well with their life, which related to evidence for the personal recovery model, by prioritising functioning well over reducing traditional clinically relevant outcomes (Jones et al., 2012; Mead & Copeland, 2000).

Despite service users' views on medication, there were narratives that also described how professionals at times failed to recognise these views, and encouraged the use of medication, rather than alternatives. Previous research has also found that less attention has also been given to encouraging healthy risk-taking with service users, even though therapeutic risk-taking and hope are essential in promoting recovery (Cleary & Dowling, 2009). It may be suggested that whilst professionals did acknowledge the process of trial and error and collaborative 'experimenting' for medication, professionals however may not be as accepting of risk taking associated with service users reducing or coming off medication due to the potential consequences of relapse this presented for service users or themselves.

Alternatively, current evidence has shown that an acceptable definition of recovery has not yet been agreed by service users, while still being practical and achievable for clinicians and services (Morrison et al., 2016). This individualised nature of personal recovery may also correlate with professionals having a the lack of a shared understanding of what recovery means in practice, which has been found to be fundamental to successful implementation of recovery-based practice (Flottorp et al., 2013; Le Boutillier et al., 2015).

Overall, the concept of recovery remains less understood among healthcare professionals or carers for BD, compared to service users' views, which reflects the wider literature of recovery for BD (Jacob et al., 2017). Initial findings suggest a continuum of views ranging from personal recovery to clinical informed recovery approaches. Services users' views were closely aligned to personal recovery, whilst carers' views remain mixed between approaches.

Strengths and Limitations

The findings from this review were limited by the lack of representation of views from different stakeholders. The existing evidence tends towards the views of service users to the detriment of the views of professionals and carers, which limited the

findings of the thematic synthesis. For carers' views in particular, one study has been included in this review, which not only makes generalising these views for carers difficult, but also generalising views for other countries problematic. The study into carers' views was conducted in China, where "cultural and political factors might affect the results of cross-cultural research in a particular setting like China" (Yang & Lê, 2008, p122), where "Chinese people tend to avoid discussing sensitive issues in detail" (Yang & Lê, 2008, p118). The under-representation of literature from carers and professionals in this review however demonstrates the relatively sparse body of research more widely exploring these views of recovery for BD. Generalising and comparing results across stakeholders, particularly carers must be approached with caution given the dominance of service user views and this review highlights the need for further research in this area.

This review attempted to use inclusion criteria that would allow for a broad range of studies to be included related to different stakeholder views of recovery for BD. All studies from the review were published during last decade, with exception of one (Russell & Browne, 2005). However, the inclusion of only peer-reviewed English papers may have narrowed the results. By also excluding 'grey' area research, this may have also misrepresented the findings, as theses, service evaluations, or case reports may have added value, particularly for views other than service users.

Whilst the quality of the studies remained high across the review from the quality assessment scoring, most studies however did not highlight the impact of researcher and participant relationship from conducting the qualitative research during quality assessments. The findings of the thematic synthesis were also limited in parts due to the depth of some of the included studies. Some studies (Maassen et al., 2019; Maassen, Regeer, Regeer, et al., 2018) did not focus on recovery as the primary focus of the research but did identify recovery as a theme from within the findings. Recovery themes from these studies only provided a vague description of participant experiences, but were extracted for this review as they were deemed

salient toward this review and valuable due to the small number of studies available investigating qualitative views for recovery in BD. The amount of evidence however from these studies contributed less towards this review than the data extracted from other primary studies included, which were more detailed in their findings. One study (Borg et al., 2013) focused on the role of work towards recovery, which may have increased the amount of data extracted describing the value of employment and meaningful activities, compared to other areas. However, this study contributed towards several identified themes and did not appear to skew the literature towards a separate theme in this area, nor dominate any individual theme.

Reporting of participant demographic data was mixed from primary studies. Ages of participants were often reported, however gender was identified for less than half (216) of participants, with one study (Fernandez et al., 2014) recruiting only female participants for female views of recovery. Ethnicity was also not reported in most studies. Although a variety of countries were present for service user groups, again this was limited to just two countries (Norway and Netherlands) for professionals and one for carers (China). This could limit the generalisability of findings from both carers and professionals to these countries, such as local traditions placed on carers maybe within China, but also limit views of professionals due to the services and polices that professionals operate within these specific countries. Furthermore all studies included within this review have originated from high income countries, which may have implications again for generalisability of findings for lower income countries where access to mental healthcare services, how these operate and awareness of mental health diagnoses such as BD for service users and families may vary significantly. For example NICE guidelines are currently used within the UK to support clinical decisions; however this may not translate to clinical decisions made by professionals in other countries. Government funding and clinical outcomes and priorities may all vary between countries. Carer views and support available will also vary based not only on healthcare decisions made, but also as discussed earlier for

cultural and political differences within countries. As such, the applicability of the findings and conclusions drawn would not translate to all international care settings.

Conclusion

The thematic analysis of 15 primary studies provided a valuable insight into views of recovery for different stakeholders and an indication of key similarities and differences. The findings in this review mirrors some of the wider literature on recovery for BD, with key important issues relating to those of the accepted theoretical CHIME framework (Leamy et al., 2011) and in line with personal and clinical recovery models.

The lack of professional and carers perspectives makes the views of these populations difficult to directly compare across stakeholders. However, this review does indicate that service user views are more in line with the personal recovery model, compared to professional views which are more closely aligned to a clinical recovery approach. Limited carers views were mixed across both recovery models, based on their own personal experiences of supporting relatives and working collaboratively with professionals. To confirm or improve on the initial views shared, future qualitative research should therefore be considered in order to address these gaps in individual perspectives from professionals, carers and other stakeholders, such as employers, particularly as these individuals play a key part in the monitoring and practical support offered for individuals with BD.

This review indicates that service users may benefit from more flexible, individualised and personal recovery focussed mental healthcare. Professionals could support service users further towards their own recovery goals, by supporting their recovery journey through ongoing learning, not only around their diagnosis, and how best this can be managed, but support them with self-acceptance and exploring their new identity and how their BD may affect their wider lifestyle, which can be closely aligned to recovery-orientated services.

Medication should be discussed collaboratively with service users and include discussions around how medication may fit with a service user's wider strategies such as

employment or hobbies to increase the use of meaningful activities to support wellbeing. This discussion may also in turn benefit professionals by increasing chances of adherence to medication. Any alternatives to medication should also be considered and discussed.

Shared decision making could support an ethos of personal recovery-orientated practice in modern mental health service provisions. However more importantly despite all the global health policy and practice agendas that mandate involvement and shared decision making this still doesn't appear to be reflected in the experience of service users. This is also reflected in professional narratives, stating that shared decisions were wanted, but currently not undertaken so in-depth working exploring the implementation of such policies in practice is required.

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Chapter 2: Empirical Paper

Abstract

Objectives: Emerging service user narratives for recovery in bipolar disorder (BD) have emphasised a preference for personal recovery approaches. Despite support provided by mental healthcare professionals appearing to follow a clinical approach to recovery, no published literature has focused on UK professionals' views. The purpose of this study was to explore and compare the views of recovery in BD from mental health professionals working within UK NHS Trusts.

Methods: Mental health professionals, with experience of working with services users diagnosed with BD were recruited using theoretical sampling from inpatient, community and early intervention services (EIS) from two NHS Trusts in England. Each professional took part in a semi-structured interview, which was analysed using constructivist grounded theory (GT).

Results: Five themes were interpreted from participant narratives. These were mis-conceptualised recovery, clinical and personal recovery, expectations for recovery, responsibility for clinical and personal recovery in BD and barriers towards personal recovery. Professional narratives about recovery in BD foregrounded clinical models of recovery and often mis-conceptualised personal models of recovery. This was exacerbated by limited expectations of recovery in BD, and perceptions that long-term recovery was the responsibility of service users and families possibly due to service level pressures and a focus on service user discharge. There were some identifiable differences between professional groups including medicalised training and acute inpatient settings, who were more likely to follow clinical approaches to recovery.

Conclusion: Despite recent attempts to increase awareness of personal recovery approaches in mental health services, much confusion around the concept of personal recovery remains including how to implement this into practice when working with service

users with BD. Service targets such as discharge rates or caseload numbers and a focus on risk management and crisis prevention often resulted in clinical recovery taking priority over personal recovery goals with service users However more training around personal recovery approaches could enable professional realisation that these approaches do not need to be time consuming, and could enable more personalised, meaningful recovery for service users with BD.

Keywords: Bipolar, recovery, professionals, views, grounded theory

1. Introduction

BD is conceptualised as a cyclical mood disorder involving periods of profound disruption to mood and behaviour, interspersed with periods of full recovery or much improved function National Institute of Health and Care Excellence (NICE) (2015). Along with mood instability, BD can be connected to significant psychosocial functional impairments, higher incidences of suicide (American Psychiatric Association, 2013; Novick et al., 2010; Rosa et al., 2010), and a reduced quality of life for service users and their caregivers (Granek et al., 2016). These consequences are partly overcome by treatments which aim to reduce symptoms and improve functioning and quality of life (Sylvia et al., 2017). However overcoming these difficulties do not meet the needs of recovery according to service users (Maassen, Regeer, Regeer, et al., 2018; Mansell, Powell, Pedley et al., 2010; Todd, Jones & Lobban, 2012; Russell & Browne, 2005).

Clinical guidelines have focused on the importance of pharmacological interventions for depression, mania as well as for mixed episodes in BD (Connolly & Thase, 2011), which can emphasise the biological and genetic basis for the condition (Craddock & Sklar, 2013). However, the goal of treatment in severe mental illness, such as BD, has gradually moved away from a dominant medical model, where mental health professionals promoted “clinical recovery” to a holistic and personal recovery-based approach, which has emerged from personal narratives from those with BD (Grover et al., 2016).

The clinical model of recovery for BD focuses on criteria of observable, clinical outcomes such as symptom reduction, avoiding rehospitalisation (Michalak et al., 2006), medication adherence, and reducing the risk of relapse (Castle et al., 2009; Lobban et al., 2010). These clinical outcomes are often measured through clinicians’ assessments, ratings, and decisions, rather than service users’ views (Kwok, 2014; Veseth et al., 2017). Both diagnosis and treatment of BD is complex. Professional views and assessments are supported by clinical guidelines, which are significantly determined by scientific evidence, however, do not necessarily reflect the preferred healthcare needs according to service

users (Maassen et al., 2018; Mansell, Powell, Pedley et al., 2010; Todd, Jones & Lobban, 2012; Russell & Browne, 2005).

Over time, the notion of personal recovery has become more prominent in mental health treatment and an important concept in the mental health field (Farkas, 2007). This alternative term for recovery was introduced by the Mental Health Consumer/Survivor Movement who argued that recovery did not require a return to normal functioning or a remission of symptoms (Davidson et al., 2005). As a divergence from symptomatic and functional recovery, personal recovery has been widely conceptualised as a "process of building a meaningful and satisfying life, as defined by the person themselves, whether or not they are experiencing ongoing or recurring symptoms or problems associated with illness" (Gilbert et al., 2013, p2). Furthermore, a systematic review on recovery processes for severe mental illnesses described a CHIME framework which emphasised the importance of Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment for service users (Leamy et al., 2016). Peer support and support groups, relationships, support from others, and being part of the community were all described as key processes for recovery, yet do not appear to be routinely discussed or implemented in current routine healthcare (Mead & Copeland, 2000; NICE, 2015; Todd et al., 2012). This offers a direct contrast to traditional beliefs about the course of illness and treatment of clinical recovery which emphasise the importance of controlling symptoms, functioning, preventing relapse and risk management.

Research into recovery and recovery-oriented care is currently underrepresented in BD research (Maassen, Regeer, Bunders, et al., 2018), and studies into personal recovery for BD have been slower to appear in the literature than other mental health conditions; however some studies from service user perspectives have emerged over the last decade. Service users with BD have been found to describe personal recovery as functioning well without medication (Cooke et al., 2010; Mansell et al., 2010), self-acceptance and redefining the sense of self (Cooke et al., 2010), becoming empowered and in control of their lives (Warwick et al., 2019), separating themselves from their diagnostic label (Russell & Browne,

2005), regaining control of ones' life or being able to achieve ones' goals (Cooke et al., 2010). These individually defined and experienced concepts of personal recovery may however challenge professionals experience and knowledge, as providing personal recovery focussed approaches, such as personal choice and self-determination would challenge established concepts such as clinical guidelines, evidence-based practice, and care pathways (Slade, 2010).

The treatment of BD in clinical guidelines remains predominantly focused on the alleviation of acute symptoms and relapse prevention (Leboyer & Kupfer, 2010), and initial findings appear to support evidence of professionals following this medicalised framework with the use of medication linked to acceptance and understanding that they are suffering from an illness (Veseth et al., 2019). Medication has also been described as one of few tools professionals have that could be relied on to relieve suffering, and as contributing most to positive changes for service users (Veseth et al., 2019). Similarly, professional use of some psychosocial interventions such as psychoeducation or family therapy follow a clinical model, which aim to reduce or at least stabilise symptoms, reduce distress, prevent future episodes, and enhance everyday functioning (Geddes & Miklowitz, 2013).

Clinical and personal recovery approaches described in previous literature may offer two opposing approaches to recovery, however an opportunity for a synthesised approach could also be considered. One study however has described difficulties professionals have faced in balancing dominant medicalised approaches in their role with personalised approaches which have meaning to service users (Veseth et al., 2019). This challenge has left professionals confused whilst working with those diagnosed with BD, and whether to encourage medication adherence or follow treatment, adjusted to service user preferences (Veseth et al., 2019). However, following a more personalised approach may be difficult to implement as typically healthcare professionals receive more training about treating illness than about promoting well-being (Slade, 2010).

Furthermore, in addition to emerging tensions from maintaining a balance between evidence-based care and working towards the best interests of service users, a systematic

review of service user views of treatment and management of BD reported that these often did not match their stated preferences (Fisher et al., 2016).

For many struggling with mental health difficulties, a key part of support can be from mental health professionals, and treatment offered by services (Denhov & Topor, 2011; Topor et al., 2012). Service users' recovery and hope for recovery in wider mental health literature has also been found to be influenced and encouraged by professionals' views and attitudes (Lester et al., 2005), which can affect outcomes such as service users' quality of life and treatment outcomes (Wahl & Aroesty-Cohen, 2010). Therefore, in general mental healthcare, professional views of recovery have a significant role for service users' hope for recovery and recovery outcomes. However, for BD, service users have described a preference for personal recovery, yet professionals do not appear to be matching the needs or preferences to service users. Furthermore, service user views in general mental health emphasise the importance of optimism and hope for recovery (Lester et al., 2005). However, professionals have been reported to doubt the possibility of recovery from BD (Munro & Baker, 2007; Wahl & Aroesty-Cohen, 2010). To date these views of the possibility or hope of recovery for BD have not been examined from a professionals' perspective.

Despite research beginning to emerge in recent years on professional views of recovery for service users with BD outside the UK, more research is needed to further understand professional views in this area, particularly from the UK where no research exploring professional views of recovery in BD currently exist, despite their potential impact on service users' recovery. From recent literature on professional views of recovery in BD, initial findings have suggested that professionals' views follow a traditional clinical model for recovery , despite personal recovery informed approaches being preferred by service users (Warwick et al., 2019).

With recent evidence from general mental health research suggesting professionals doubt the possibility of recovery, this may influence clinical approaches taken (Wahl & Aroesty-Cohen, 2010). Alternatively, it is unclear how national changes in mental health policy for supporting recovery influence for professionals from an organisational level within

the UK. These differential approaches may however cause professionals to become confused as to how or whether they should incorporate more service users' preferences into this clinical framework (Veseth et al., 2019).

In BD there is a clear association between medication non-adherence and poor outcomes from treatment (Gibson et al., 2013), with some service users expressing ambivalence towards medication (Mansell et al., 2010). Furthermore, service users have been found to disagree with healthcare guidelines used by professionals (Mansell et al., 2010), stating that generalisations were made that did not reflect the individualised nature of BD. Therefore, there is a good rationale for exploring professional views for alternatives approaches for recovery in BD. Furthermore, in addition to the lack of research in the UK, initial findings elsewhere have only described professionals generally, despite differences in training and education prior to qualifying in various mental health disciplines. No evidence has been discovered to authors' knowledge that have determined whether different mental health professionals therefore differ on views of recovery for BD.

The findings from this study will add to limited, preliminary evidence for understanding various healthcare professionals' views of recovery for BD, and potential barriers or facilitators for implementation in clinical practice in the UK. Ultimately this research could have implications for staff training or opportunities for professional development and improve outcomes for service users through furthering understanding between service user and professional views.

2. Materials and Method

2.1 Design

A constructivist grounded theory (GT) design was considered an appropriate methodology for this study as it is able to go beyond describing and exploring to explaining more complex phenomena in areas that have not yet been fully captured by theory (Birks & Mills, 2016). GT is also particularly suited to investigating 'how' questions and can focus on

micro-level actions and interactions, which may be useful for looking into smaller pieces of information from individual participants and comparing these across individual or wider teams or professional disciplines as they begin to describe a particular issue (Sbaraini et al., 2011).

Constructivist GT argues that neither data nor theories are discovered. Instead, constructivism highlights the subjective interrelationship between the researcher and participant, and that the development of theoretical ideas are a joint construction of meaning (Charmaz, 2003). A researcher's view on the data is crucial when exploring an understudied area, so in order to use a research methodology that would provide an ontological and epistemological fit with this position, a constructivist (Charmaz, 2003) stance was considered most suitable for the present study.

This study was written according to criteria for reporting qualitative studies (COREQ) checklist (Appendix F).

2.2 Ethical Considerations

Ethical approval was obtained from University of Liverpool Research Ethics Committee in November 2019 (Appendix G). Approval was also obtained from the local NHS Research and Development (R&D) teams for two NHS Mental Health Trusts in North West of England, which both provide inpatient, and community services (Appendix H).

2.3 Participants

Service team managers from community mental health teams (CMHT) within identified NHS Trusts were contacted by phone or email and were asked to share information sheets (Appendix I) and consent forms (Appendix J) within their local teams. During this process several teams also invited the researcher to present this study at team meetings. Where this was done, any interested participants were left with information sheets and consent forms. Information sheets contained contact details for the researcher

conducting the interviews (DK). Interested parties contacted DK directly in order to discuss participation further and express an interest in participation.

Participants were eligible for inclusion if they met the following criteria:

i) Mental healthcare professionals of any discipline/setting, within included NHS Trusts and;

ii) current/ previous professional experience of working directly with at least three adults with any diagnosis of BD within the last 5 years.

2.4 Sampling

In constructivist GT, purposive sampling is used initially to begin data collection, through selecting participants with experiences of the research area to inform early research questions and concepts (Charmaz, 2003; Sbaraini et al., 2011). For this study, participants were sourced from various professional disciplines with a wide-ranging duration of experience within healthcare settings to enable diversity in professional experience for data collection, providing participants met inclusion criteria. Each participant was interviewed, and transcripts were analysed in turn, consistent with constructivist GT methodology (analysis described in section 2.7).

As the prominent categories emerged (Thornberg & Charmaz, 2015), this narrowed the focus for additional participants who were then recruited in line with the process of theoretical sampling, rather than purposeful sampling. Theoretical sampling is a core process which guides where, how and whom further data should be gathered from to further develop a theory, based on data obtained until no new information emerges (Charmaz, 2003, Corbin & Strauss, 2014).

The first eight participants were recruited from community mental health teams (CMHT), and consisted of five nurses (RMN), two psychiatrists and a psychologist. The next five participants were recruited specifically because they worked in areas other than CMHTs, as initial findings suggested that different views on recovery may be affected by the setting a professional works in. These five participants worked within and were recruited from

inpatient or early intervention services. Therefore, at this stage, attempts were made to gain more information on views of recovery from professionals in alternative settings, to provide richness to the data and potentially capture any variation in views found during data comparison as per grounded theory (Thornberg & Charmaz, 2015). Participants were not selected based on the length of their experience, or duration worked in mental health settings, however this was recorded for demographic purposes to describe the sample and potentially to understand the findings further.

At the start of recruitment, it was unknown how many participants would be required due to theoretical sampling of GT, where recruitment would stop once no new themes were emerging. When sharing information sheets with service managers or potential participants at local meetings, all professionals approached were made aware of both the nature of theoretical sampling and saturation. It was explained that even though participants may meet the inclusion criteria on information sheets and contact the researcher to take part, there was also a requirement to gain views from a wider variety of professionals from different teams and NHS trusts. Therefore, on occasion, individual participation was not required at that point to prioritise collating views from professionals of different disciplines and teams to refine emerging theory in line with GT principles.

Theoretical saturation was tentatively agreed following 13 participants. However, an additional interview was completed in order to conclude theoretical saturation had been achieved.

In total, 16 participants requested to take part in the study. A total of 14 participants were recruited from two NHS trusts between September 2019 and January 2020 and asked to take part in individual semi-structured interviews. One psychologist was unable to take part within the recruitment period, and a RMN approached the research team, but was not required to take part due to theoretical sampling and agreed to be contacted at a later point in recruitment if needed, however was not required due to theoretical saturation being achieved prior to participation. None of the participants recruited were known to the interviewer prior to study participation.

2.5 Interview Procedure

After identifying participants as described for theoretical sampling (section 2.4), the participants were invited to an individual semi-structured interview, to discuss their experiences and views of recovery for BD. Participants were all given the choice of face-to-face interviews at their workplace or another agreed location, or over the phone. Phone interviews were offered to maximise recruitment and make participation as convenient as possible if needed, however this option was not taken up by any participant. A university contact person was used for lone working when required and followed local lone working policies. Interviews were carried out in a private room on NHS premises. No one other than the interviewer and participant were present during interviews.

Following consent, participants were asked some demographic questions in order to further describe the sample. Demographic information collected asked for participant's i) current job title ii) employing NHS trust, iii) length of employment within both current job and mental health services. This demographic data potentially would give further understanding to the qualitative data obtained, along with comparing commonalities that may be found e.g. among different teams and for transparency for the sample.

For the interviews, an interview schedule (Appendix K) was created based on information found from previous literature (Bonney & Stickley, 2008; Veseth et al., 2012, 2016, 2017; Warwick et al., 2019). The interview schedule was used to initially identify some key areas for discussion; however, the interviews were directed by points raised by each participant. All professionals were encouraged to discuss openly about their experiences, and points of interest were explored further through additional follow up questions. No identifiable information was collected during the interviews. At the end of the interview the researcher confirmed that participants were not concerned or affected by any aspect of their participation in the interview. All participants confirmed they knew where to find contact details for the researchers, and independent contact for they had any further questions or

concerns at a later date, or withdraw from the study in accordance information detailed within the consent forms.

As a key principle for GT, following each interview, audio recordings and transcripts from each participant then informed the interview schedule for the next interview (Thornberg & Charmaz, 2015). Each transcript examined and new emerging themes were added to the interview schedule for further exploration at future interviews. Data collected from individual transcripts were also compared and contrasted to previously collected data to determine any key patterns that required further exploration.

2.6 Post Interview Procedures

All interviews were conducted face-to-face and were audiotaped using an encrypted Dictaphone. Interviews lasted between 18.16 and 49.38 minutes. Recorded data were transferred as soon as possible to a university computer and stored on a university server and immediately deleted from the Dictaphone at this point. This server was secure and regularly backed and only accessible to the research team. All participants were given two weeks to contact the researcher if they wish to withdraw from the study and request that their data be destroyed, after this period data became anonymised and could no longer be identified.

Each recording was transcribed verbatim into a word document and was password protected. Any identifiable information provided by participants, such as names and locations were removed during transcription process.

The researcher transcribed the first four interviews within two weeks of the interviews taking place. The remaining ten interviews were transcribed by a transcribing company approved by University of Liverpool and with confidentiality agreements in place. Each transcript was sent by secure electronic transfer and assigned the corresponding participant number in order of data collected, to match with anonymised demographic information. All interviews were transcribed verbatim.

Following each interview, the researcher made a summary of the interview, which was used to note down emerging ideas shared by participants. Any new areas discussed were added to the interview schedule, for follow up and discussion at future interviews and determine when theoretical saturation had been achieved. The process of exploring emergent ideas to potentially explore in subsequent interviews was considered important as it was in line with the iterative process of grounded theory (Charmaz, 2003). At this point, the reflective journal was also used to identify initial ideas regarding possible themes (Appendix L).

2.7 Analysis of Interview Data

The main feature of GT is the relationship between data collection and analyses are interrelated and iterative (Thornberg & Charmaz, 2015). The researcher conducting the interviews listened to the audio recordings and read transcripts several times prior to data analysis commencing. Becoming immersed in the data is key for GT, as gaining a sense of the data is important for allowing the researcher to gain an overall feel for the data's scope and meanings.

Each transcript was uploaded onto the computer software Microsoft Excel (2016), which was used to organise the transcript text (raw data) ready for data analysis. Raw data were coded using three stages: initial, focussed and theoretical coding (Sbaraini et al., 2011). Initial coding involved analysing raw data on a line by line basis, to produce as in-depth an analysis as possible from the data. Any descriptions, events, activities, or phenomenon of interest found from raw data, such as a view expressed by a professional on any aspect of recovery, was coded in this first stage as initial coding. As the analysis continued other instances of the same phenomenon from the raw data are also coded. This cycle of collecting data and analysing codes continued, and theoretical sampling was used in order to continue searching for new data until no new or categories emerge, known as theoretical saturation (Sbaraini et al., 2011).

Throughout the coding process, the researcher continuously reviewed the data, and compared this to the emerging concepts, known as constant comparison. Focussed codes were then assigned to initial codes that appeared more frequently, or across similar descriptive initial codes, such as medication use, family support or service user responsibility. Theoretical codes were then created from focussed coding, which required the researcher to select related codes then became integrated into categories. Similarities, differences, and relationships between categories were an important focus for theory development. These categories became the beginnings of an emerging theory as more categories began to emerge. Data were constantly compared throughout the reviewing process both within and across themes to make sure themes and theories generated reflected the data collated. These were also discussed during regular research team and supervision meetings.

Constant comparison helps to minimise against researcher bias by continually 'challenging concepts with fresh data' (Charmaz, 2003).

Memos in the form of written records including emerging concepts and ideas for theory development were used to support the analytical process. An extract is provided in (Appendix L). These memos aid the process of making comparisons between codes and categories, and highlighting gaps in data, which then identifies possible areas for further interviewing and theoretical sampling (Charmaz, 2003). This process of constantly reviewing data collected after each interview and amending the interview schedule for subsequent interviews for more or less relevant areas of discussion follows the inductive and iterative nature of the GT approach (Sbaraini et al., 2011).

To ensure the quality of the data, regular discussions were had within the research team to discuss the process of data analysis and interpretations. One author (HB) fully coded 10% of the data from different time points of data collection to ensure quality of coding and adequate depth of data coding.

The authors repeatedly met to discuss codes, categories and model development following the completion of categories. Diagrammatic models were shared during

discussions which represented categories, and codes assigned to these, and how these had been integrated and developed (Figure 2). The overarching theoretical model and hypotheses were refined throughout discussions until all authors were happy with the findings and that theoretical saturation had been met. The use of diagrammatic model to visualise the developing theory is a key feature for GT (Sbaraini et al., 2011; Thornberg & Charmaz, 2015).

2.8 Researcher's Position

For GT, it is important for the researcher to acknowledge the position of reflexivity, being able to examine their own reactions and thoughts, whilst undertaking qualitative research, and understand how values and assumptions may influence the data analysis. To assist with monitoring how these may influence the interpretation of data, it is recommended that GT researchers have 'present appropriate reflections on their role in the dynamic process of analysis' (Brocki & Wearden, 2007). To aid this process, and facilitate transparency, a reflective journal was kept throughout the recruitment and analysis process (Appendix M).

The researcher conducting the interviews (DK) was a white female in her 30's, was brought up in the North West of England, where the interviews were carried out.
While conducting the research, the researcher conducting the interviews worked as a trainee clinical psychologist. Prior to gaining a place on the clinical psychology training course, the researcher conducting the interviews had seven years experience working as a research assistant within the Spectrum Centre for Mental Health Research at Lancaster University.

From being involved within several research studies related to BD, and through interviewing service users with BD, the researcher noticed some service users reporting having differing views on their recovery with professional who support them. From later completing placements in CMHT and inpatient mental health settings as a trainee clinical psychologist, the researcher gained a further interest in these views, and noticed variations across each placement and professionals worked with. This interest was further inspired by

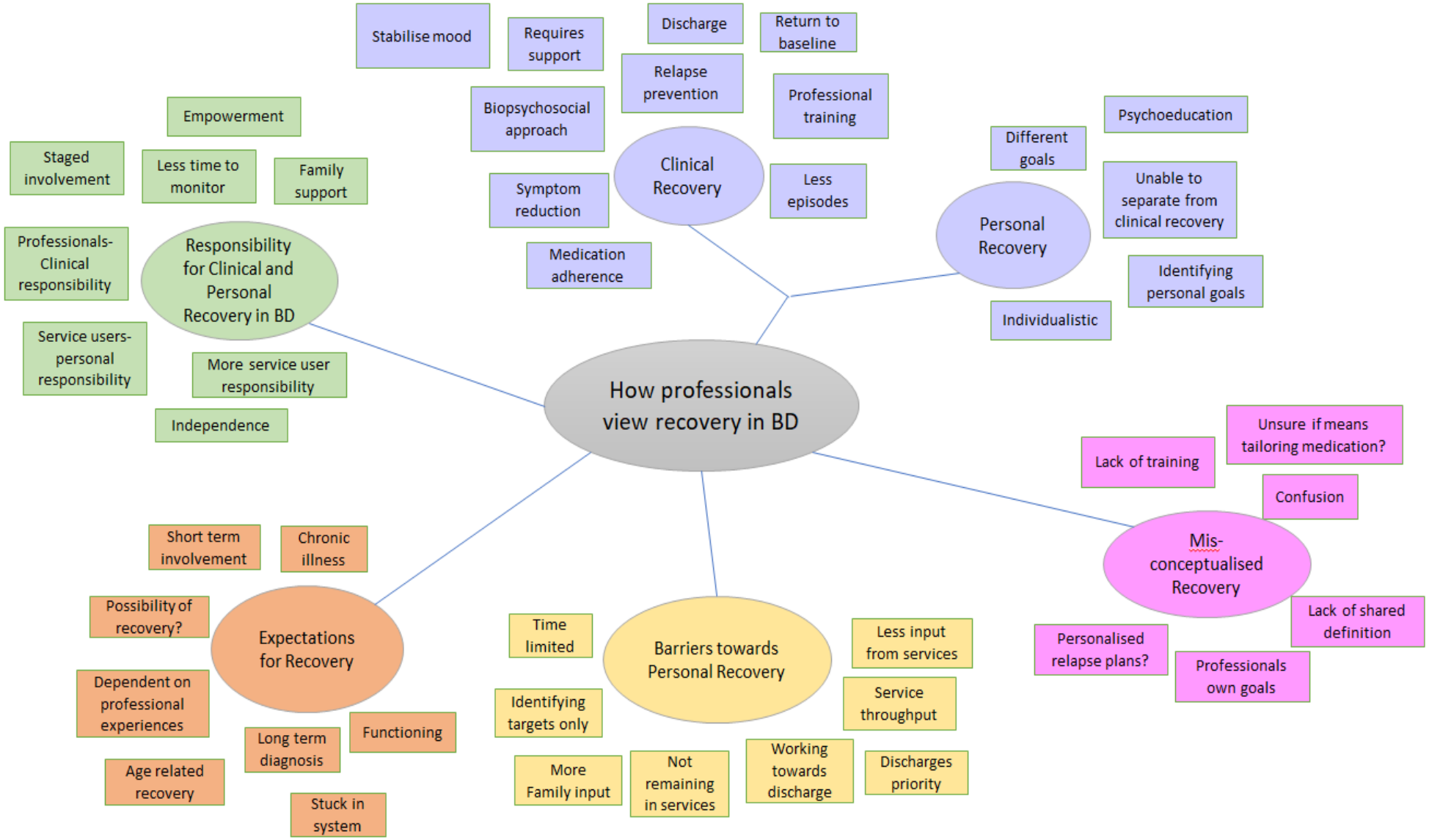
discussions with the researcher's clinical and academic supervisors as to whether these approaches were informed by an awareness of service user preferences or limited to service approaches or individual professional practice.

During the research process the researcher did not consider herself to be explicitly aligned with a particular approach, and as a trainee was taught to focus on flexible person-centred biopsychosocial approaches during training. Over the course of the study however the interviewer noticed an awareness of how some professionals worked towards different approaches, which made the interviewer curious to whether this was from either personal preference, from gained experience over time or from constraints of a service worked in. The researcher had not completed placements within either of the NHS trusts recruited from.

Both authors HB and SJ undertook the role of supervisors for the duration of this study. HB is a female, non-clinical Health Services Researcher and Senior Lecturer at the University of Liverpool. Her work has focussed on increasing service user and carer involvement in mental health services and is predicated on the value of lay support networks in managing chronic physical and mental health conditions. SJ in a male Professor of Clinical Psychology at Lancaster University. His work has focused on the coproduction of research into bipolar and related conditions with people with lived experience to develop better psychosocial interventions that effectively target the needs and priorities of people to live well alongside their mental health experiences. Both supervisors became involved in this study to further understandings of conceptualisations of mental health recovery in secondary mental health services.

Figure 2

Organisation of focussed codes and categories



3. Results

The demographic information (Table 6) showed that a total of nine RMNs were recruited, across CMHT (n=6) and EIS (n=3) settings, with seven females and two males. Three psychiatrists were recruited from CMHT (n=2) and inpatient (n=1) settings, with all three psychiatrists being male. Two psychologists were also recruited from CMHT (n=1) and inpatient (n=1) settings. Both psychologists were female. Six participants were recruited from NHS Trust 1, and eight from NHS Trust 2. At least one participant was recruited from an inpatient, EIS and CMHT from both NHS trusts.

The analysis of data describes professional views of recovery for those with BD. Data were analysed through the processes of initial and focused coding, categorising, memoing and constant comparative analysis, described in section 2.7.

As explained earlier, theoretical sampling was pursued only once the data analysis allowed the construction of some categories that needed further exploration (Thornberg & Charmaz, 2015). Different healthcare settings and professional disciplines were therefore considered and discussed. The presentation below will be based on the final analysis of the data following the completion of theoretical sampling.

The data analysis led to five key themes being constructed from interview data. These themes were developed from collections of focused codes with the highest relevance to the research question, which described below were used to determine dominant? professional views of recovery from BD

Table 6
Participant Demographics

	Title	Gender	Service	Length of current role	Length in profession	Length of interview (minutes)
Participant 1	RMN	Female	CMHT1	8 years	15 years	24.26
Participant 2	Psychiatrist	Male	CMHT1	4 years	9 years	37.56
Participant 3	Psychologist	Female	CMHT2	12 years	12 years	30.28
Participant 4	RMN	Female	CMHT2	2 years	5 years	18.16
Participant 5	RMN	Female	CMHT2	15 years	20 years	24.03
Participant 6	RMN/Team lead	Male	CMHT1	20 years	25 years	49.38
Participant 7	Psychiatrist	Male	CMHT2	14 years	20 years	23.45
Participant 8	RMN	Female	CMHT2	12 years	30 years	23.18
Participant 9	RMN	Female	EIS1	18 months	18 months	22.42
Participant 10	Psychologist	Female	Inpatient 1	5 years	12 years	42.01
Participant 11	Psychiatrist	Male	Inpatient 2	10 years	20 years	41.21
Participant 12	RMN/ service lead	Female	EIS2	12 years	30 years	25.20
Participant 13	RMN	Female	EIS2	1 year	3 years	30.17
Participant 14	RMN	Male	CMHT1	8 years	6 years	36.49

Theme 1: Mis-Conceptualised Recovery

This theme described misconceptions of personal recovery, as when describing this model it was often mis-conceptualised with professionals often identifying personal recovery goals themselves. These misconceptions were often fuelled or exacerbated by service targets and discharge plans.

Ambivalence and Confusion around Personal Recovery.

When describing personal recovery, there appeared to be some misconceptions amongst participants, possibly related to a lack of shared definition. Several professionals appeared ambivalent around what this approach was, and often conflated or confused this with other approaches to care, such as holistic or personalised medical approaches. Ambivalence was identified within interviews with EIS, CMHT nurses and inpatient psychiatry and in an interview with one CMHT psychiatrist. Some professionals described personal recovery as being an individualised clinical approach, focussing on tailoring treatment to person rather than to a diagnosis.

> *"I think you have to tailor the treatment according to individual cases. Similarly, I think personal recovery, again, would be relative and patient to patient" (Participant 2).*

Initially in some interviews participants stated they understood personal recovery and described following this approach. However, as narratives developed, it became apparent that these professionals were confused by the term personal recovery, instead describing this as tailoring medication, personalising care plans or relapse prevention plans.

> *"…for personal recovery we have to look at care plans differently and what recovery is differently, because each person's different. For example, you might look at discharging somebody who is under our service, but somebody else might take a little bit longer, six months, because you've got to do it gradually, it's got to be a graded plan." (Participant 8)*

These plans remained focussed on reducing symptoms and strategies for ultimately, preventing relapse. These focussed on clinical recovery, rather than personal recovery and identifying goals for what each service user would describe as being recovery for themselves.

Other participants described not having much awareness or training on recovery but viewed personal recovery as something other than a clinical recovery approach.

> *Participant: I haven't been on a bipolar training course- you know, looking at recovery. So, I'm just guiding myself here really. So, maybe that is something that would be beneficial for recovery.*
> *Interviewer: Have you had much in terms of training around clinical recovery, or personal recovery-focused approaches, or…?*
> *Participant: Not here. No. But I come from drug and alcohol services where recovery was a really big thing when I started. So, I think through the whole of my nursing career, clinical recovery has been a big thing, and talking about recovery, and hope, and being hopeful, and aspirational. But aside from focussing on symptoms, it's not something I've had training on here. (Participant 14)*

Professionals Own Conceptualisations of Personal Recovery.

Some professionals described part of their role as being able to identify personal recovery goals on behalf of a service user when they are unable to easily identify their own goals, or having difficulty with this.

> *"It must be hard, someone sitting in your living room, saying, "Right, well, what do you want to do?" They'll be like, "I've no idea." It's quite a generalised thing, isn't it? I think as a professional you've got to pick it out." (Participant 1)*

However for those participants who did provide some descriptions of personal recovery, these conceptualisations were not found to be mutually exclusive to clinical recovery. Those who initially discussed personal recovery concepts or approaches, also combined this with clinical recovery, due to either an emphasis on medication for their role, or due to limited time or capacity in their role or that they appeared to struggle with the concept of personal recovery in their role.

> *"But even just leading a normal family life- like, I guess, a normal routine- you know, being there for the kids, and their partner, and whatnot. Those things seem normal, and seem to be what recovery is about for people, I think… But I think that it would be a big indication for somebody that is not on medication, and possibly not under a service anymore, that that's recovered. You know, and even though their moods do fluctuate, you know, and still recovered, because they're managing without those things." (Participant 14)*

Theme 2: Clinical and Personal Recovery

This theme refers to the clinical and personal models of recovery professionals described being aligned to.

Professional narratives prioritised the view of clinical recovery. This was thought to be related to the medicalised focus of professional training and the focus on medication for stabilising symptoms within some professions.

Clinical Recovery.

Professionals provided descriptions of recovery such as experiencing less frequent episodes, or episodes being less severe. With any reduction in symptoms, professionals believed that this clinical recovery would enable a good quality of life for service users.

> *"Bipolar disorder, actually the ideal resolution would be that they should be able to come to their baseline in their functioning, and should be able to maintain that is*

recovery… they should have longer periods when they are free of episodes of mania and depression. Episodes should become less frequent and each episodic period should have less fluctuations of the baseline" (Participant 7).

However some professionals also argued that despite a reduction in frequency or severity of episodes, some professionals reported poor outcomes for recovery in BD and often difficult to achieve:

"Recovery is possible, but only if the right support is in place" (Participant 2).

"…the ideal medication, social support, and psychological therapy are needed to enable [recovery] to happen … but recovery is generally not achievable for most service users as their mood often fluctuates." (Participant 6).

Clinical vulnerability was reported by one professional as a reason for this limited opportunity for recovery:

"The vulnerability issue will continue to be there whatever the cause. Genetics is the most important one, chemical imbalance or stress factor, whatever; that will usually be there. We try to reduce as much as we can, but we cannot change what the person is susceptible for" (Participant 11).

Throughout discussions about how professionals approached or worked towards recovery, professionals across all settings described the importance of adhering to medication or finding the right medication to achieve recovery, stabilise mood and monitoring symptoms or early warning signs to prevent relapse.

"So, our role is looking at medication for at least a year, to give them the best prognosis to prevent relapse" (Participant 9).

"I usually see people when they come in… when there's [been] a relapse and the first line of treatment is medication" (Participant 10).

Other professionals described their role towards recovery as focussing on medication administration and adherence:

"In the community as a CPN now I suppose it's monitoring them and their moods when you're meeting up with them and showing that they are taking their medication" (Participant 4).

Some professionals described a staged approach to recovery. Recovery beyond medication was not often considered initially during acute phase of illness, as priorities were on stabilising symptoms before other approaches were considered:

"So in acute cases we have to use medication and once they're relatively stable, then obviously we can use psychotherapy and all the other modalities" (Participant 11)

Sometimes wider aspects of recovery were alluded to but these were constrained by more dominant views of clinical recovery. Some professionals described being able to measure recovery through being able to spend time doing hobbies, with children, look after their accommodation, socialise, follow a routine, and generally function in their everyday life. These were possible, but once clinical symptoms had stabilised:

"My job is to… stabilise their mental health so that the symptoms of whichever illness they've got is well managed. At that point, then, start trying to promote other things that might aid the recovery process to get people better… If we can get control of your mental health, and stabilise everything, the world is your oyster" (Participant 6).

Four professionals reported having a negative view of clinical recovery due to its perceived dominance in health services or a frustration with the emphasis being on medication (Participants 1, 5, 8 & 10). Despite agreeing with previous views that medication was valuable for symptoms, this overreliance on medication by psychiatrists minimised the value of input by nurses with less emphasis for other interventions that nurses could offer as alternatives.

"Well, sometimes the medical model can be a quite stifling and it's frustrating sometimes when the emphasis is on medication, rather than other things, that can be done, like psychoeducation or therapy. It seemed to overshadow the work and input [nurses] had. I think that things are improving in that because I do feel listened to by colleagues, consultants" (Participant 5).

This was reflected in narratives which reflected the view that a combination of medication and psychological therapy was the basis of helping people recover. These professionals therefore viewed recovery through clinical approaches but preferred a more holistic definition of recovery.

> *"I think potentially, different staff may work to different recovery models as in like so many people, there are a couple I think that are more medical, … It's not the holistic, it's not the recovery, and it is that, "Give you meds, there you go." Well, I think sometimes maybe having that mix is helpful" (Participant 1).*

Psychiatrists who followed a purely biomedical approach to BD were described by other professionals as being 'old school psychiatrists' as they only considered medication, compared to a newer generation of psychiatry who were more open to considering a combined approach of medication and psychosocial approaches to clinical recovery.

> *"So, I don't think… maybe a bit more of the older school nurses who has just prescribed some medication, and maybe… in terms of trying to achieve recovery" (Participant 14).*

However, the two most recently qualified professionals also described noticing more experienced nurses in the team focussed on maintaining people with medication to manage conditions, compared to their own training courses prior to qualifying that focused on recovery-based models and recovery pathways. When discussing their own practise for BD, both professionals acknowledged how their course had an emphasis on personal recovery, which other professionals in their team who qualified previously had not experienced during their training and had limited knowledge of.

> *"I've only been qualified for a year and a half, so we had two modules, I think, on recovery models and things like that. So, it was quite recovery focussed. Whereas some people, older nurses in the team, have never heard of a WRAP plan or anything like that. It's more about managing conditions." (Participant 9)*

Other professionals appeared to place more emphasis on working with families and the wider support networks and to share their expertise, which enabled supporting the

service user to identify early signs of relapse and to support medication adherence, in the absence of professional support.

This approach fits with the role found within community and EIS teams, as this role was described as working with the wider support network, such as family and colleges. This approach is potentially furthered by professionals in EIS describing having more time to work on personal recovery-based approaches with service users than community teams.

> *"I think within community mental health teams, a lot of it's on the [service user] to go away and put things into practice. When they're going through therapy with our team, the therapists expect them to go away and put things into practice. I think we do take on quite a big role, as care co-ordinators, in recovery." (Participant 9)*

Personal Recovery.

From the 14 participants, only one professional (Participants 9) was able to describe personal recovery and what was involved in following a personal recovery approach. This professional described measuring recovery as an individual being able to have a job, return to work, work within a team, and manage the stresses of work effectively. Alternatively, recovery would be getting someone into work or education, or being able to run their home.

> "In bipolar, no. I mean, I think, because I wouldn't ever class recovery as just getting better. I would class it as living a life that lives up to your expectations." (Participant 9).
>
> "having a normal life, whatever that entails, that's not impacted by having low lows and high highs. They would still have episodes, but they just don't tip into needing mental health input." (Participant 9).

Participants 3 and 10 also described some personal recovery approaches than clinical approaches, as their work involved formulations, which enabled discussions around understanding of BD and informs the changes needed for change to occur from the service

users' perspective. This was suited to identifying individual goals and non-clinical recovery objectives. However, these professionals often described not being able to work towards identified targets and that service users were often discharged before targets could be achieved, however they were able to develop recovery plans, which service users could continue with post intervention.

Theme 3: Expectations for Clinical Recovery

This theme described professional views on whether clinical recovery was possible, and what is required to achieve this. Expectations were affected by time in services and professional background.

Professionals who had worked within mental health services over a longer period described how service users previously remained in services, often for many years. BD was previously viewed as a lifelong, chronic illness with lifelong vulnerability to relapse from life events. Long term supervision and monitoring by professionals and services was required to promote medication adherence. There was no focus towards recovery and service users were told that they had a severe mental health condition and that they would remain under the care of a psychiatrist, with medication for life or a long-term basis.

Some professionals also argued that despite a reduction in frequency or severity of episodes, some professionals reported poor outcomes for recovery in BD and often difficult to achieve:

> *"…recovery is generally not achievable for most service users as their mood often fluctuates from the baseline, rather than simply being in or out of episode" (Participant 7).*
>
> *"Recovery is possible, but only if the right support is in place" (Participant 2).*
>
> *"the ideal medication, social support, and psychological therapy to enable [recovery] to happen" (Participant 6).*
>
> "[recovery] is only able to go so far… living as much of a full life as a person can do, despite their BD" (Participant 10, Psychologist)

Clinical vulnerability was reported by one professional as a reason for this limited opportunity for recovery:

> *"*However even then the vulnerability remains… due to the genetics, chemical imbalances, and life stresses, despite trying to reduce stress the person will always be susceptible to relapse (Participant 11).

> "Even if people became stable quickly after having some sort of treatment, some medication or whatever, usually the vulnerability remains, their susceptibility to the illness is always there" (Participant 11).

More recently there has become an increased acceptance by all professionals interviewed that service users can recover in-between episodes with professionals now viewing their involvement as short-term, focussing on moving towards developing a life outside of services. Professionals described more emphasis now being placed on supporting younger generations of service users to recover than older generations who they viewed as 'stuck in the system' and less likely to 'buy into' the prospect of living a fuller life suddenly.

> *"we have people who've sat under this team for 15, 20, 30 years, who have just been seen week after week. Someone's had a brew with them 15 years ago, and then they've kind of got into the system of being a [service user]" (Participant 1)*
>
> *"I've got a caseload of people at both ends of the age spectrum. I probably do treat them both slightly different. There is more of an emphasis on helping a younger person to recover than the older generation, that are stuck in the system." (Participant 6)*

In addition to the changes over time, professionals varied on their expectations for recovery. Psychiatrists and EIS nurses described BD as being a lifelong, chronic illness, therefore recovery would be difficult due to the vulnerability or susceptibility of BD. For

anyone under EIS with BD, there was an expectation for this to be a long-term diagnosis with work focussing around managing and preparing for the next relapse.

“So, it's about managing the build-up of stress again, which is difficult, because they think that as soon as the symptoms have gone, that's it, back to normal. But yes, quite often people have expectations that they'll get better very quickly and stay well, but its then monitoring and preparing for a future relapse” (Participant 9, EIS nurse).

CMHT nurses’ expectations for recovery however were more optimistic than other professionals. Like psychiatrists and EIS, CMHT nurses viewed service users with BD as being vulnerable to relapse. However, this view appeared more positive from these professionals as they gave examples of individuals who were well for many years in between relapses and viewed a relapse as a temporary lapse from which they could recover with good support and consistency. CMHT nurses therefore viewed recovery as possible, depending on how relapse is defined and responded to. CMHT nurses also described the importance of giving service users with BD opportunities, such as employment as these enabled a routine and structure as strategies for remaining well in the long term.

“Then there are other [service users] who probably had their last manic relapse maybe five years ago, so it is possible with the right combination of support, medication and opportunities” (Participant 6, RMN)

In terms of differences between services, recovery was viewed as limited for inpatient services, due to the acute nature of someone’s relapse and the focus being on stabilising symptoms. Recovery however could be done in stages and recovery work was viewed as possible following discharge from hospital into CMHTs or when discharged home.

> “Often, we get asked questions about timings of interventions. There is no point delivering interventions with somebody who is not ready or at a stage of wanting to consider that, and often that’s when someone is ready to return back into community

following an admission, that's when the recovery work can start" (Participant 3, Psychologist).

Theme 4: Responsibility for Clinical and Personal Recovery in BD

This theme described professional views on who they felt was responsible for recovery. With service users now remaining in services for shorter durations, and more of an emphasis on throughput for services, professionals believed there should be more responsibility placed on service users for their own recovery. Four from the nine professionals from CMHT thought service users with BD should be encouraged to become responsible for making choices with respect to taking their medications, and for approaching support when needed, rather than professionals being responsible for continuous monitoring of high or low mood, despite these not happening in practice.

"For me, it's very much the goal setting of, "No, you need to be responsible for your medications. You need to be responsible for coming to me for the care" (Participant 1)

Professionals across CMHTs described a staged approach to shifting responsibility for recovery. During acute stages, professionals agreed that they should take more responsibility initially and can provide psychoeducation to identify common triggers or early signs of relapse. However as someone begins to gain an ability to then self-monitor and practice coping strategies independently or with family support, professionals argued that they should gradually phase out this level of responsibility towards the individual taking responsibility for the next stage of recovery themselves. Professionals would then support service users with medication, but other aspects of recovery were the individual's responsibility. The same CMHT professionals also believed that pressure to discharge service users enabled service users to become less dependent on services, with more of a

pressure towards enablement for individuals to manage their condition themselves and their own support network, outside of services.

> *"I feel it's important to empower them to take a lead, if they're not too acutely unwell… it's the whole dilemma of how much do services rush in and respond to early signs of relapse. How much do we encourage the service users, themselves, to take responsibility for managing that and self-management of that?" (Participant 3)*
>
> *"There has been more push towards enablement of the [service user] to manage their condition better and not being dependent on us. There has been that approach." (Participant 7)*

However, this complex work of building a valued life was viewed by professionals as goals that needed to be achieved without professional support. Professionals viewed their role as limited for personal recovery to only identifying these goals for post discharge.

Professionals viewed younger service users as being more accepting of professionals placing more responsibility on them, with professionals being more in the background, compared to older generations of service user who were used to more emphasis being placed on professionals for recovery.

> *"My younger [service users], I am pushing and pressuring them into thinking and doing things that might sit slightly outside of their comfort zone at certain times because it needs to happen. Otherwise they will end up in the same situation [as older service users]." (Participant 6)*

However, some service users with more experience of previously being told what to do by healthcare professionals were described has having lost confidence in their own ability to self-manage. Three professionals described working with service users who did not want to support their own recovery.

> *"…but sometimes they don't want to do that, and it's difficult to try and look at what else we can give them when we're giving them everything we can" (Participant 8).*

Due to professionals having less time to monitor service users for early signs of relapse, professionals viewed service users and families as being ideally placed to assist with monitoring symptoms than themselves. Family members were viewed as more able to monitor early relapse signs than professionals and may notice early signs of relapse before the person with BD. Professionals also described relying on families for support in notifying them when available support is no longer working, requiring professional input at that time. All CMHT professionals, with exception of one psychiatrist, viewed relying on professionals less as a positive move forward for service users. With professionals providing medication and education to wider families, this allowed the individual and support network to support themselves, and enabled professionals to provide support when needed such as at crisis.

> *"Getting families involved, making relationships with them as well as your [service users], is absolutely key to any kind of success in terms of managing someone's condition… and is able to then assist me to look after someone." (Participant 6)*

Family support was described as very important, but some also acknowledged that this was not available for everyone. Where family was not available, professionals helped identify support from community such as friends, or a church community, or could make referrals to third sector or charity groups.

However, despite nearly all professionals that described the benefits of family and community support, most also described this as being counterproductive at times, and undermining recovery as well as supporting this. Even though families are generally good at identifying signs of relapse, families through their closeness in monitoring, can at times be overinvolved in matters, interfere with affairs and not give enough space. This at times can push relatives with BD, and act as an external stress, and contribute towards becoming unwell. Family members were often not included in decision making, however were expected to act on decisions made for them. Professionals described family carers as adding an extra layer of complication to decisions whereby relatives may not agree with identified goals for

recovery or having different views to an individual on the outlook of recovery. This puts them at risk for being labelled as difficult if they question any decisions made by professionals.

> *"Often, in reviews, there will be family members. Sometimes that can be a good thing, but sometimes that can be an added layer of complication when they might be expressing different views to the service user themselves." (Participant 3).*

Theme 5: Barriers towards Personal Recovery

This theme describes how professionals encountered barriers to working towards personal recovery for people with BD, due to service pressures for short-term interventions and organisation priorities for discharge.

Focus on Discharge

Within CMHTs, both nurses and psychologists described service pressures around discharge being a barrier to personal recovery and working towards different goals to service users at times.

> *"Pretty much as soon as I'm allocated them, I'm thinking, "How can I discharge them, to give them their independence back, to not need us anymore?" That's very much how I work. I explain that to people… so actually then trying to look at, from my perspective, a recovery goal. It's always going to be very different from that person's because it's like abandonment, isn't it?" (Participant 1).*

Any input from services would highlight that this would be short term and to be able to identify when this input was to end right from the start. Professionals described service pressures to discharge someone from services once they had clinically recovered. In community teams this was often discussed from the start of professional input, with participants describing discharge as being part of the recovery pathway.

> *"… currently as care coordinators we assess, treat and discharge, that's what our pathway is now, because we've got so many people waiting to access services, that*

we have to discharge people as quick as we can, really. It's not ideal, but that's what we're working on. We have to do that." (Participant 8)

"…we have to have a plan of what we're doing. Then discharge… there is an emphasis on discharge really, if people aren't discharged, if people don't recover enough to discharge, then our service - which is what's happened at the moment – starts backing up" (Participant 3)

Risk management/crisis prevention limits time spent on personal recovery goals

CMHTs also described the complexities of balancing service targets with service user goals. Service targets such as discharge rates or caseload numbers and a focus on risk management and crisis prevention left limited time for discussing wider personal recovery goals with service users. Instead firefighting and managing crises were viewed as a priority for their time by services and line management.

"…there are a lot of other barriers. A lot of paperwork has to be done, getting up to date reviews and up to date documentation. If somebody is in crisis, there is a lot of work to be done around that. That might mean that they don't get a chance to look at recovery type work, even though the crisis work will be part of the recovery. Sometimes it's a bit about firefighting rather than doing some meaningful work with the person." (Participant 3)

"I think a lot of the time, we've got that many [service users] we fire fight a lot." (Participant 1)

Due to the short-term duration of interventions and service input, even where individual personal recovery goals were discussed and identified, these were not achieved or worked towards due to discharging as soon as symptoms of BD began to reduce.

When we are working with people, we want to discuss whether they want to back to work, and what they want to do. Nowadays that has become more difficult, because we discharge service users before they reach that stage" (Participant 7)

"It's annoying for us, but it's more detrimental to our service users" (Participant 1)

Personal Recovery as More Time Consuming

Professionals viewed a personal recovery approach as more time consuming and less effective than a clinically focussed approach. As a result, clinical recovery was perceived as a more achievable short-term goal which was closely aligned to the wider service and organisation targets associated with their role. Some professionals however described not even aiming to discuss personal goals or aims for recovery or even described having to refer service users to third sector organisation considered better placed to undertake personal recovery work such as support with employment or increasing recreational activities or support.

"Well, it's been a long time since we've been able to do anything like that. We're reliant on other places like [community service] to refer to. So, we wouldn't be doing any of that input with them, we just don't have the time. We would refer to that agency if they needed that." (Participant 5)

Differences between Professionals

Despite service pressures being mentioned by many professionals, there were some variations between professionals. EIS did not describe difficulties in these areas, as they described not having the same service pressures as CMHT and were able to place more time and support for individuals. This was due to EIS having lower caseloads and were expected to work with someone for up to three years, so described not having as much pressure for discharge or short-term interventions.

> "I think it is, because we keep lower caseloads here as well… so yes, the government objective is …to equip them the best for the future, moving on. So, it is a really recovery focussed team, but the onus is on us to make sure they've got the tools they need to go ahead and recover" (Participant 9).

One nurse who had recently qualified also described how they had noticed the system pressures to work towards a clinical model of recovery which was different to these models they were taught whilst training as a nurse.

> "Whereas, when I started, the government and the commissioners were talking about recovery, and it leaped down, it dripped down into us as practitioners, "You've got to get people recovered." (Participant 12)

4. Discussion

The primary aim of this study was to explore professional views of recovery for BD, and how these were related to other professionals and settings within UK NHS Trusts. Professionals' narratives were found to focus on clinical models of recovery and even when they attempted to discuss personal recovery, this was often mis-conceptualised. This was impacted by individual factors such as service setting, professional background and length of time in services, often limited expectations of recovery from BD, perceptions that recovery (especially personal recovery) was the responsibility of service users and families, and organisational contexts which focus on throughput and discharge.

Previous literature has identified two models of recovery, clinical and personal recovery (Slade, 2010). Service users with BD have been found to identify with personal recovery (Cooke et al., 2010; Mansell et al., 2010; Russell & Browne, 2005; Warwick et al., 2019), but their views of treatment and management of BD does not appear to match their preferences (Fisher & Lees, 2016). Compared with service user views of recovery for BD, professional views have been relatively neglected, with no research on professional views

being conducted within the UK on recovery for BD, despite their involvement and role in recovery processes, and changes made to national recovery-focused policy in mental health services they work in (NICE, 2015).

Misconceptions about personal recovery were common from findings in this study, which relates to difficulties in defining personal recovery in mental health literature (Bullock et al., 2000; Young & Ensing, 1999), causing confusion and debate within the mental health community (Davidson et al., 2005). Individualised, personal recovery approaches have also been found to be difficult to implement due to professionals knowing and understanding more about treating illnesses rather than promoting wellbeing (Slade, 2010). Furthermore, navigating personal recovery within a dominant medical model has been found to be difficult for professionals (Veseth et al., 2019) whilst maintaining a balance between evidence-based care and working towards the best interests of service users (Keyes, 2005). This may explain why service user preferences are not routinely discussed or implemented in current healthcare (Mead & Copeland, 2000; Todd et al., 2012), and potentially leave service users feeling disempowered and unable to achieve their recovery goals.

Many professionals emphasised clinical approaches, describing recovery as being measured through clinical outcomes, such as symptom reduction for mania or depression, or less frequent episodes. Professional background also appeared to affect perceptions of recovery and a preference for certain models of recovery. Training routes into nursing and psychiatry were described as focussing on clinical recovery, with more experienced nurses describing a complete lack of training into alternative approaches, such as personal recovery altogether. A lack of training or awareness of personal recovery approaches for professionals in more clinically trained professions such as psychiatry or nursing, may explain views for BD as being a long-term condition that could only be specifically targeted and maintained with medication. This study also identified specific features of BD, such as manic episodes, that inhibited professionals from pursuing personal recovery and contributed to limited expectations of recovery amongst professionals. These views have been replicated with professionals in wider mental healthcare and found professionals to

doubt the possibility of recovery (Wahl & Aroesty-Cohen, 2010) or have little hope for recovery (Munro & Baker, 2007), and instead professionals focussed on symptom management and compliance with treatment (Bedregal et al., 2006). These clinical views have been replicated in this study, with recovery only being possible if the right support is in place, such as medication and support networks, despite service users being found to express ambivalence towards medication (Mansell et al., 2010).

Evidence for the effectiveness of training in personal recovery-based approaches (Mead & Copeland, 2000) have found not only an increased knowledge of professionals, but also more pro-recovery attitudes, such as an increased consideration for holistic and person-centred care, but also a shift from focussing on maintenance to working towards improving mental health service user identified outcomes (Gilburt et al., 2013). However, to transform mental health services and professional views of recovery, this training may need to be implemented from the start of healthcare training to increase awareness of personal recovery approaches (Giusti et al., 2019).

Most newly qualified nurses all described a heavy influence on recovery-focussed approaches to BD, which suggests a change in training approaches over time, to focus more on alternatives to clinical approaches. However, these nurses still described falling back on clinical approaches due to organisational pressures such as pressures to discharge, and focuses on risk management and crisis prevention. Psychologists' views of recovery also appeared to be more closely aligned to a clinical model, despite training not being heavily medicalised.

Although evidence has found that most clinicians believe that they work collaboratively, with shared decision making, there is evidence to the contrary (Hamann et al., 2014). Service users in mental health have identified more clinician-led than shared approaches (Slade, 2017). In this study, psychiatrists very much emphasised the need for medication as a requirement for BD, and did not discuss using service user preferences, or alternatives to clinical recovery. Nurses, who described more consideration being given to service users' preferences than psychiatrists however still defined their role as ensuring

medication adherence to prevent relapse. These experiences have been found to be negative by service users as passive or even coerced approaches (Harris et al., 2017), and may explain some of the prevailing dissatisfaction with care that you find in the service user literature (Fisher et al., 2016). Most medication adherence interventions require reminders, supervision or increasing general motivation to take medication, but do little to understand or address this underlying dissatisfaction (Slade, 2017). In the time-pressured services described by professionals, it may be more efficient for professionals to engage service users more in being responsible for managing their care and identifying goals, which have been shown to have better outcomes, engagement, and if necessary increased treatment adherence – all of which will improve outcome (Slade, 2017). Evidence supports that personal recovery approaches do not need to be time consuming and can increase shared decision making and increase engagement with professionals in the long-term (Say, 2003). However professionals from this study viewed personal recovery approaches as taking more time than clinical, which could explain falling back on this model.

Service users' recovery and hope for recovery in wider mental health literature have however been found to be influenced and encouraged by professional views and attitudes (Lester et al., 2005), which can affect outcomes such as service users' quality of life and treatment outcomes (Wahl & Aroesty-Cohen, 2010). This raises concerns around professional views for a lack of possibility for recovery in BD and potential consequences, particularly for older generations of service users who were maintained on medication and viewed as having no opportunity for recovery by professionals, as they may then also have no hope for recovery themselves. Some service users have been found to experience recovery approaches as abandonment or failed by the system after years of being medicated (O'Keeffe et al., 2018). Abandonment and 'stuck in the system' were terms described by CMHT nurses from these findings.

As more emphasis on recovery-based approaches have been introduced over time (NICE, 2015), more emphasis on personal recovery-based approaches have been placed for training which contrasts with clinical outcomes (Murray et al., 2017). Research into recovery

for psychosis found that service users who received recovery-orientated services noticed a recognition of their own responsibility for recovery (O'Keeffe et al., 2018). This may enable opportunities for values found to be important for personal recovery in BD such as being viewed as separate to a diagnosis (Russell & Browne, 2005), feeling empowered and able to control over one's life (Warwick et al., 2019), and able to achieve one's goals (Cooke et al., 2010). This provides evidence to support professional practice in placing more responsibility on the service user, however this may benefit from an approach by some professionals who described a gradual phasing out of support, so service users feel better placed to take ownership of this responsibility.

Interventions can offer the potential to support someone through personal recovery processes (Davidson et al., 2005). Professionals can provide information or teach self-management skills, to empower service users towards personally meaningful goals, which have been processes valued by service users with BD (Cooke et al., 2010). However, for professionals in the current study who considered personal recovery work, this was viewed as being possible only following the stabilisation of symptoms with medication as the starting point of recovery processes, which replicated the wider literature (Veseth et al., 2019). Furthermore, when identifying goals for recovery work, professionals often described identifying goals for recovery on behalf of service users. This work can reduce the opportunity for empowerment for service users, and for them to work towards meaningful goals.

Research has also found that healthcare systems can undermine the capacity of staff to provide recovery focussed approaches (Williams & Tufford, 2012). Professionals in CMHT and inpatient settings described pressures from organisational targets and limited time resources, which prioritised the need for focus on crisis management and discharges. In these settings, professionals described encouraging service users to become responsible for their own recovery. Clinical approaches such as medication, or psychoeducation to encourage relapse prevention were viewed as less time consuming than personal recovery interventions or approaches. However despite limited time resources described in some

services, personal recovery goals could be identified and incorporated in existing psychosocial interventions to develop self-management strategies to increase involvement in meaningful activity, improvement in self-efficacy, self-management and a reduced reliance on formal and informal support networks (Jones et al., 2011), and may therefore not be as time-consuming as professionals assume.

Connectedness, hope and optimism about the future, identity, meaning in life and empowerment have all been highlighted as central features to personal recovery from the CHIME framework (Leamy et al., 2016), but do not appear to be routinely discussed or implemented in current routine healthcare according to wider literature (Mead & Copeland, 2000; NICE, 2015; Todd et al., 2012). These individually defined and experienced concepts of personal recovery can however be implemented into clinical practice by professionals, without being time consuming as described in professional narratives. Service users could benefit from professional's openly discussing and offering collaborative work to support service users in identifying their own personal recovery goals, rather than solely clinical goals (Cree et al., 2015). Professionals could empower service users in taking a lead for increasing their knowledge for alternative strategies than medication for wellbeing, and identifying areas in their life that can support their identity of who they are as individuals, rather than focussing on their diagnosis or symptom reduction.

The findings of the current study highlight the potential value of lay support networks (family members) and third sector agencies in supporting personal recovery for people with BD. The use of family, carers and third-party agencies were described as able to support recovery, often considered outside of the remit of CMHTs given service pressures. However, this study also demonstrated that professionals described their role as being responsible for clinical recovery but viewed service users and lay support networks as responsible for personal recovery. Relationships with family or carers were reported by professionals in this study to aid therapy as powerful allies and co-therapists. A recent review found that both service users and carers wanted increased involvement, specifically in the assessment and planning of care (Bee et al., 2015). Furthermore the majority of carers have been found to

describe a need for improved consultation between the service user, carers and professionals (Cree et al., 2015), with service user/carer involvement as improving the relationship between service user and professionals (Cegala et al., 2007). However over involvement was also discussed by professionals when involving carers in monitoring early warning signs or sharing information with professionals. This therefore highlights barriers to involving family carers that may need to be addressed.

Whilst not all carer relationships are beneficial for interventions for those with BD (Veseth et al., 2017), it has been found that service engagement with family members can improve health outcomes for service users (Heru, 2006). One psychologist in the current study described how families expected there to be a treatment to cure for service users from professionals, increased involvement with services and third parties should increase carer understanding and awareness to further support service users. However before simply placing additional responsibilities onto carers to enable further personal recovery interventions, professional support would still need to be provided in order ensure this involvement is beneficial to service users goals, and to also ensure carer burden does not occur. Therefore, professionals would need to consider where the additional time placed for this support would be best suited for each individual service user, requiring an emphasis on identifying personal goals collaboratively first.

4.1 Strengths and Limitations

This study was conducted to examine professional views of recovery in BD within the UK. Grounded theory was deemed the most appropriate method, due to its ability to explore complex phenomena in an understudied area (Birks & Mills, 2016). Theoretical sampling enabled professionals to be interviewed from different disciplines and services of interest, where data may be richer, compared to random or convenient sampling and allowed theory development. The interactive design and constant comparison were key features of GT, which added strength to the analysis (Charmaz, 2003; Thornberg & Charmaz, 2015). This theoretical sampling enabled professionals to be recruited from nursing, psychology, and

psychiatry backgrounds; however one limitation from the sample could be that views from other healthcare disciplines have not been considered, such as social work, occupational therapy or support workers. However, this initial exploratory study remained focused on interviewing identified professions from data.

Further research could explore additional professional disciplines in more depth. Although a range of nurses were recruited for the sample from CMHT and EIS, no nurses were recruited from inpatient settings. Recruiting additional participants such as inpatient nurses, along with additional inpatient psychologists, may have offered more in depth, or alternative views to those offered by community teams. Having one inpatient psychologist within the sample also at times offered single divergent views, which may have been substantiated by additional professionals being recruited.

Theoretical saturation was reached once 14 participants were recruited; however this sample was also limited to professionals with formal qualifications. Although inclusion criteria were open to any mental healthcare professionals, theoretical sampling resulted in a focus on specific healthcare roles due to participant discussions around the impact of various training routes. However, it is interesting that no professionals without formal qualifications came forward for this study. Peer or support worker roles may offer alterative perspectives on results discussed and this study may not therefore reflect the views of these other professionals.

The identified sample of participants however covered a wide range of years of employed service in mental health roles, ranging from 18 months to over 30 years. This enabled changes to recovery in services over time to be discussed, along with exploring changes to training of mental health professionals more recently from those more newly qualified.

Whilst collating data and discussing views on recovery during interviews, one possible limitation was whether staff were describing recovery for BD or their views on recovery for mental health in general. The authors were aware of this being a possibility during data collection and undertook several strategies to mitigate this risk. Points raised by

participants during interviews were checked with the interviewer to confirm these as being views for BD. From confirming with participants, this limitation appears to have been reduced, as demonstrated by participants describing the nature and examples specific to working with BD.

4.2 Conclusion

This study has increased the understanding of professional views towards recovery for BD within the UK. Despite recent attempts to provide training into the awareness of personal recovery approaches for some disciples such as nursing, this remains misunderstood for BD and viewed as particularly difficult to implement where BD is viewed as clinically dominated within the healthcare system. Unique features of BD appeared to decrease expectations of recovery amongst professionals.

It is acknowledged that time resources for interventions may be limited in the current healthcare system, service barriers, such as pressures to discharge; caseload and crisis management often take priority. Therefore further research should concentrate on increasing opportunities for personal recovery approaches within these time-pressured services, such as supporting service users to identify personal recovery goals, alongside clinical goals, which could empower service users to self-manage, and enable family or carers to assist in a more meaningful way.

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